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**How do men who have sex with men currently understand,
evaluate and respond to HIV risk? A mixed methods analysis of
an internet survey in a post-antiretroviral society.**

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A thesis submitted in fulfilment for the degree of Doctor of Philosophy at the

Open University - School of Health and Social Care

Date of submission March 2016

Dedication

This PhD thesis is dedicated to the memory of my late parents, Kevin and Bridget Kavanagh, who made me who I am today. Sorely missed and never forgotten.

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I would like to express my special appreciation and thanks to my supervisors, Dr. Sarah Earle and Emerita Professor Rose Barbour. You have been tremendous mentors for me and I would like to thank you for encouraging me in my research and for allowing me to grow as a researcher.

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A special thanks goes to my family, who stood by me on what turned out to be a very difficult journey for us all. To my nieces and nephews who inspire and give me hope for the next generation. And finally, as I keep the best until last, special thanks to Dionisis for being my rock, for never judging me by my research and for loving me for just who I am.

Abstract

This thesis sets out to examine how men who have sex with men (MSM) currently understand, evaluate and respond to HIV risk. The aims of the study were to explore key areas of HIV risk understanding, including how HIV risk was understood in a post-antiretroviral society and how masculinities affect this risk understanding. In addition, key aspects of the negotiation of sex used by those who were single and in (open) relationships were considered. An examination of a variety of mass media HIV prevention interventions was carried out to explore what viewing them tells us about risk perception and response. Of key interest to this research was how these understandings of HIV risk were evolving within the context of the shifting definitions of love, with the introduction of formalised relationship structures, and sex, caused by the impact of antiretrovirals in the MSM communities. This study unified the results from quantitative and qualitative data that emerged from an online mixed methods survey to unravel the experiences of a convenience sample of 557 UK-based MSM. This survey incorporated a mixture of both open and closed questions, vignette questions and made the use of visuals to allow nuanced responses to emerge. The findings reveal how these shifting definitions of sex and love are affecting how men understand HIV risk, the consequences for the negotiation of sex, and indicate various improvements that may need to be made to address these issues.

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Chapter One - Introduction

HIV/AIDS: From Pessimism to Optimism

HIV¹ first came to the attention of the US Centre for Disease Control in 1981 when there was an upsurge in demand for a drug used in the treatment of pneumocystis carinii pneumonia, one of the most common AIDS-related disorders (Bloor, 1995a). This suggests that large numbers of people had already become infected with the virus at this stage prior to it being recognised or defined. Initially known as GRID, it was renamed AIDS in 1981 after it became clear that other groups besides gay men were dying from the virus (Nettleton, 2006). The HIV virus itself was eventually isolated in 1983 with further strains being identified by 1986, which remains one of the major obstacles to vaccine development (Bloor, 1995a). The introduction of HAART in 1996 brought with it a new optimism about survival with HIV (Rowniak, 2009). Although the dormancy period prior to the introduction of these antiretrovirals was up to fourteen years in rare cases, the majority of people developed full-blown AIDS and died within a number of years (Buchbinder et al., 1994). HAART's predecessor, AZT, was not successful in every patient and had a number of toxic side-effects (Stine, 1993). HAART, on the other hand, used a combination of antiretroviral drugs to reduce the viral load and stop progression of the disease. The introduction of these antiretroviral drugs has significantly reduced morbidity and mortality from AIDS in developed countries (Mocroft et al., 2003). While side effects and resistance can occur with these antiretroviral drugs, the variety available means that these can be minimised and most users can expect to live 'normal' lives without developing full-blown AIDS². The case of the Berlin Patient, the first man to be cured of AIDS, has made the medical profession more hopeful that a practical cure for the HIV virus may soon be realised (Cohen, 2011). In addition, the

¹ A number of key terms, many of which arise in the first pages in this thesis, are explained in more detail in the accompanying glossary.

² In 1996, a person who acquired HIV at the age of twenty had a life expectancy of 19 years. In 2011, a twenty-year-old person acquiring HIV could expect to live until they were 73. However, this remains 13 years fewer than the life expectancy of a seronegative individual (Marcus et al., 2016).

functional cure of HIV that appeared in the VISCONTI cohort gives new optimism that HIV can be suppressed within the body without the need for a lifetime of antiretroviral treatment (Lopez, 2013).

The first major trial of treatment as prevention (TasP), known as HPTN 052, began in 2005 and studied 1,736 serodiscordant couples across three continents (Cohen et al., 2012). The objective of the study was to investigate if antiretrovirals taken by the seropositive partner reduced the sexual transmission of HIV within serodiscordant couples. Although this trial focussed primarily on heterosexual couples (only three percent were homosexual) and on couples who were starting antiretrovirals, the results indicated that antiretrovirals reduced the possibility of transmission within the couples by 96% (Cohen et al., 2012). In addition, the research also found that the earlier the seropositive partner started antiretrovirals (with higher CD4 counts), the less likely they were to pass on the virus to their partners. While many countries are accepting TasP as standard practice in HIV treatment and prevention, the British HIV Association advises that 'starting treatment 'early' to prevent transmission to a sexual partner be explored on an individual patient basis' (Young et al., 2016, 414, emphasis authors' own). A more recent ongoing trial, known as the PARTNER study, examined 888 serodiscordant couples to establish the possibility of HIV transmission where the seropositive partner has an undetectable viral load. The preliminary findings of this trial were presented at the AIDS 2016 conference in July 2016. In contrast with the previous study, almost forty percent of PARTNER's participants were MSM³ couples and all seropositive partners started the trial with an undetectable viral load, as opposed to beginning antiretrovirals in HPTN 052. Seronegative partners were excluded if they had taken either PEP or PrEP. The findings show that 'no phylogenetically⁴ linked transmissions occurred

³ The term MSM is used throughout this thesis for consistency. However, if authors have specifically referred to 'gay men' or any other terms, then their term is used in place of MSM.

⁴ There were eleven transmissions of HIV in the trial, but none of these transmissions were from the primary partner in the study.

over eligible couple-years of follow-up, giving a rate of within-couple HIV transmission of zero, with an upper 95% confidence limit of 0.30/100 couple-years of follow-up.' (Rodger et al., 2016, 171). These results suggests that seropositive men with an undetectable viral load are highly unlikely, although the possibility cannot be ruled out, to transmit HIV to their partners.

However, the progressions made in the field of antiretroviral treatment have not been limited to the seropositive communities. Antiretroviral treatment has now been developed for use on seronegative men as a preventative means to halt the development of the HIV virus after/before exposure. Since 1989, post-exposure prophylaxis (PEP) has been used on healthcare workers who had been exposed to HIV-infected fluids through workplace accidents (Henderson & Gerberding, 1989). However in 2005, the use of PEP was expanded to include other groups of people who had been exposed to the virus and constitute a serious risk of seroconversion (Omrani & Freedman, 2005). PEP has to be taken consistently over a period of twenty-eight days and crucially needs to be started within seventy-two hours of exposure to the virus. Currently, PEP cannot be prescribed by general practitioners and men who wish to avail of the treatment must attend genitourinary clinics and/or accident & emergency departments within the seventy-two hour window period. This may cause difficulties for men who live in more isolated communities and/or do not wish to face the potential embarrassment of attending such locations. While the exact effectiveness of PEP in the MSM communities is debated, it is assumed to be significantly, but not one hundred percent, effective if taken correctly (Benn et al., 2011). Therefore, PEP allows seronegative MSM who have been potentially exposed to HIV to avail of an additional measure to significantly minimise their risk of seroconversion.

Research on PEP has been surpassed by more recent studies on the effectiveness of pre-exposure prophylaxis (PrEP) on reducing the possibility of HIV transmission prior to engaging in

high-risk sex. PrEP is different from PEP in that the antiretroviral drugs are taken *before* potential exposure to HIV. In order for PrEP to be effective, it may need to be taken consistently and has a number of potential side effects. PrEP is intended to be taken over the short term with people stopping treatment when they believe that they are at a lower risk of contracting HIV. During the data collection stage of this research, a significant PrEP trial was taking place on MSM in England (PROUD study) and research emanating from similar research around the globe was indicating that PrEP was highly effective at reducing the possibility of HIV transmission, although efficacy rates varied between studies and therefore confusion about the effectiveness of such treatment remained. The first such major trial of PrEP (the iPrEx trial) took place between 2007 and 2009 on 2,499 men and transgender women who have sex with men in nine cities across four continents. The results indicated that PrEP reduced HIV infection incidence by 44%. Significant as this result may be, blood tests from participants revealed that only 51% took the required treatment correctly, suggesting a true efficacy rate of 92% (Liegler et al., 2014). Similar research took place on heterosexual serodiscordant couples in Africa between 2008 and 2010 and revealed a higher efficacy rate of 73% among those who were prescribed Truvada® and 62% among those who were prescribed Tenofovir⁵ (Mujugira et al., 2011). It was in the context of these mixed results that data collection took place.

While the PROUD study was ongoing at the time of data collection, results that have emanated from the trial since then have shown that among the 544 MSM who took part in the research, there was an efficacy rate of 86% (McCormack et al., 2016). A similar PrEP trial (IPERGAY) was taking place in France and Canada at the same time as the PROUD study. However, the major difference between the IPERGAY study and other previous PrEP research was that IPERGAY focussed upon the effectiveness of PrEP taken 'on demand' (Molina et al., 2015). This involved

⁵ Both Truvada® and Tenofovir are types of antiretroviral drugs.

participants taking PrEP at intervals just before and after bareback sex, thereby avoiding the challenges of long-term adherence of daily pill taking. The results from the IPERGAY study revealed the exact same efficacy rate as the PROUD study, suggesting that this method of taking PrEP was as effective as taking the drug daily over the long term. In addition to avoiding the difficulties with adherence, this method of administering PrEP also significantly reduces the cost implications of the drug (Ouellet et al., 2015). The most recent research on PrEP (funded by Public Health England), suggests that over seven thousand MSM could be prevented from acquiring HIV each year, if 25% of highly-active MSM took PrEP alongside increased testing and the implementation of TasP (Punyacharoensin et al., 2016). As a result of the continued positive results from research, the World Health Organisation expanded its 2014 recommendation that PrEP be offered not only to MSM, but also to all population groups at risk of HIV infection (WHO, November 2015). However, information emanating from the United States, where PrEP has been available since July 2012, indicates that many MSM are not availing of the treatment (Morgan, 2016). While this may be due to the cost associated with PrEP (which is covered by many insurance plans), it has been suggested that the stigma around PrEP ('PrEP whores') may be making many MSM reluctant to take the treatment (Spieldenner, 2016).

However, even with the strength of the research results and the WHO recommendation, at the time of writing, PrEP is still at the trial stage in the UK. Recently, PrEP became available privately through a GUM clinic in central London, but the cost associated with such treatment means that it remains out of reach for many MSM. As a result, PrEP activists have recently set up a website with information and how to legally import cheap generic PrEP for their own use from countries in south-east Asia. This resonates strongly with importation of experimental drugs to the United States, which took place at the height of the AIDS crisis. In much the same way as PrEP activists are doing today, the FDA (Food and Drug Administration) in the United States were accused of

delaying the introduction of drugs that were available to AIDS patients in other parts of the globe.

However, these radical changes in the development of new biomedical prevention technologies have also impacted upon HIV risk understandings for both seropositive and seronegative men. Sex between two seropositive men has been known to pose no further risk of HIV transmission, as both partners are already infected. Similarly, no risk exists between two seronegative couples as long as they are both monogamous, or adhere to negotiated safety for sex outside their relationship (Flowers, 2001). However, the biomedical prevention technologies discussed above have led to new landscapes of risk emerging for men trying to navigate sexual risk. As Keogh & Dodds (2015, 798-799) point out:

‘landscapes of risk may be redrawn by the [prevention technologies] with individuals having additional factors to weigh up in calibrating their sexual risk practices...as new prevention options emerge, the meanings and associations traditionally attributed to HIV may be further re-framed.’

These new risk landscapes provide men with new opportunities to have safer sex without the use of condoms. For example, seronegative men can use PrEP and/or PEP as a means of protecting themselves from acquiring HIV, even when they engage in bareback sex with other men. Seropositive men with an undetectable viral load can now be confident that they are highly unlikely to transmit HIV to seronegative partners. While sex between serodiscordant men may have been previously understood as high-risk, where the seropositive partner has an undetectable viral load, this risk is now significantly reduced. However, risk still remains when seronegative men have bareback sex with seropositive men who have a detectable viral load, or with those who are unaware that they have seroconverted. This is a particular concern in the UK, as many MSM are diagnosed with HIV at later stages of infection (Skinsley et al., 2015a).

As infectiousness is at its highest during the initial stages of infection, it is possible that these men would have had sex with other men prior to them being aware of their newly acquired serostatus (Seage et al., 1993). Later diagnosis increases this risk further, especially if serosorting is used as a means of risk reduction. This implies that the boundaries of risk have become blurred as these new landscapes of risk emerge. Therefore, HIV risk can be seen as a continuum in which some sexual activities are understood as risky, while others are not.

This thesis is concerned with exploring how MSM understand their risk of HIV infection in the context of these developments. The introduction, and subsequently developments, of antiretroviral treatment are likely to have impacted upon how MSM now understand their risk of HIV acquisition. In the context of these new developments, this thesis seeks to investigate the impact of these changes on MSM's understanding of their HIV risk.

Rationale and Aims of this Research

My interest in carrying out this research stemmed from my own experiences of changing attitudes towards condom usage. Growing up in a country dominated by Catholic morality and coming to terms with my sexuality at the height of AIDS crisis and when homosexuality was still illegal in Ireland⁶ was no easy task. In 1997, I entered into a long-term monogamous relationship with another man. Although rumours had been circling about the effectiveness of new antiretroviral drugs at the time, HIV was still considered, in my mind at least, a death sentence. Many men refrained from engaging in anal sex with casual partners and condoms were part of

⁶ Unless otherwise stated, 'Ireland' refers to the Republic of Ireland in this thesis. Any references to Northern Ireland are specified.

our everyday realities given our fear of acquiring HIV. In a sense, I believed that my monogamous relationship protected me from the reality of HIV and I forced it out of my mind. Twelve years after the beginning of that relationship, I found myself single once again. However, the world that I stepped back into was a completely different one from the world I left. In a new country, I found myself in a city with the highest percentage of HIV in the MSM communities in the UK. Yet attitudes towards condom use had also changed. Men were not as insistent about condom use and I found myself in the position of having to negotiate condom use with other men; something that was strangely unfamiliar to me given that condom use had been the previously taken-for-granted norm in my experience prior to 1997. This experience triggered questions in my mind about what had happened in the intervening period. Why had condom use become something MSM had to negotiate? Was I sending signals to other men to indicate a preference for bareback sex? What had happened to mass media interventions and why were men not receiving these messages? I was also aware that differences between Ireland and the UK may have played a role in answering these questions. After all, Ireland has always had a significantly lower percentage of HIV in the MSM communities than the UK. Perhaps men in London had a more fatalistic view of HIV than my experience in Ireland. It was this change, and interest in finding answers to these questions, that led me to carry out this research.

The first aim is to explore how MSM understand their risk of infection in a post-antiretroviral society. Since the introduction of antiretroviral treatment twenty years ago, these drugs have had an enormous impact on the life expectancy of seropositive men (Fang et al., 2007). In addition, the use of antiretrovirals in the form of PEP, PrEP and TasP has meant that the possibility of HIV transmission and acquisition is further reduced (Kubicek, et al., 2015). Yet research has continued to show increases in the number of MSM acquiring HIV (Skingsley et al., 2015b). It has been suggested that the effectiveness of antiretrovirals has made men reconsider

their risk of HIV infection as the virus has evolved from a death sentence to a long-term chronic, but manageable, illness (Nettleton, 2006). While medical experts are able to define HIV risk, they are unable to reduce, or remove, this risk, so men are left to make their own decisions about how to identify a person who is a risk to them (Blaxter, 1990). Therefore, this research intends to explore MSM's HIV risk understanding and the mechanisms they use to recognise who is a potential risk to them.

The second aim of this research is to examine how masculinities inform HIV risk and response. Given the importance of masculinities to many MSM (Mutchler, 2000), it is possible that counter-discourses of risk affect their understanding of their risk of HIV infection. In this context, risk is seen as more exciting and may be interpreted as a means for men to transgress rules imposed by wider society (Lupton & Tulloch, 2002). Therefore, those who break rules by not using condoms gain more 'masculine capital' than those who abide by the condom code (Thomas et al., 2014). From this perspective, it may become desirable for men to break rules, even though one of the consequences of this decision is that they put themselves at increased risk of HIV acquisition (Dean, 2009). Masculinities may also play a role in open relationship formation. Given the emphasis on transgression, it may be that those who most closely align with the ideals of hegemonic masculinity may be least likely to make rules about condom use in extra-dyadic encounters (Wheldon & Pathak, 2010). Therefore, how masculinities informs HIV risk and the impact this has on their response to such risk is of crucial importance to this research and an appreciation of this will allow for a more nuanced understanding of how MSM understand their HIV risk.

The third aim of this research is to understand how informal/formal relationship agreements impact upon HIV risk. There is considerable variation in the ways in which relationships are

formed within the MSM communities (Frank & DeLamater, 2009; Hickson et al., 1994). Some men maintain that their relationships are monogamous, yet also engage in extra-dyadic sex with other men (Shernoff, 2006), while those in open relationships may not engage in sex with other men (Blasband & Peplau, 1985). If men in 'monogamous' relationships have sex with other men without the partner's knowledge, they may be reluctant to inform their partner, which has consequences for the spread of HIV and/or other STIs within the primary relationship (Adam, 2006). On the other hand, relationship agreements made by those within open relationships may be unclear with one partner believing that an act is forbidden, while the other has a different understanding of this rule (Duncan et al, 2015b). Non-monogamies create an additional dynamic in MSM's understanding of HIV risk and therefore need to be explored in this research.

The final aim of this research is to investigate how MSM negotiate sex prior to, and at the point of, sexual engagement. Given the extent of HIV-stigma in the MSM communities, seropositive men are less likely to disclose their serostatus to other men (Smit et al., 2012, cited in Murphy et al., 2015b). In addition, some men believe that the receptive role in sex influences a man's ability to assert a desire for safer sex, as to speak about condoms may be interpreted as challenging the active partner's implicit dominant role (McInnes et al., 2011). As a result, much negotiation of sex happens in a non-verbal manner with a variety of cues and allusions used by men to indicate their serostatus (Stirratt, 2005). However, the difficulty with cues and allusions is that men may interpret them differently resulting in risks being taken in the belief that there was a mutual understanding the cues/allusions given (Adam, 2005). An investigation of these cues and allusions will take place to explore the extent of their use across the communities and their impact upon MSM's decisions about partner choice.

The Structure of this Thesis

Chapter two of this thesis provides the context for this research and highlight important developments that are crucial for an understanding of this research. A discussion of the extent and effects of HIV-stigma, particularly on the disclosure of serostatus, will take place. In addition, the introduction of new relationship structures in the form of civil partnerships and gay marriage have an important impact on this research. While civil partnerships have been available for a number of years, gay marriage was introduced in the UK during data collection. Therefore, it is important to have an understanding of the impact of these relationship structures as they relate to the wider context in which this research is set.

A critical analysis of the available literature is carried out in chapter three. This analysis examines the literature across each of the four aims of this research discussed above. In addition to examining the literature on sexual health promotion theory, this chapter draws on the concept of risk and explores how it is understood across a variety of different settings. This will give a more rounded picture of how HIV risk is understood in the literature and informs the analysis and discussion of findings.

Chapter four focusses on the methodology used to conduct this research. It provides the rationale for using the online method and explains the mixed methods approach. Details of how the survey was constructed, including the use of vignettes and visuals, are discussed. Given the sensitive nature of this research, details are also provided about how sensitive issues were addressed in the survey and how questions were worded to ensure intrusiveness was limited. The issues raised by the pilot survey are examined alongside a discussion of how each of these

issues are addressed. The sensitive nature of the research also raised a variety of ethical issues, which are addressed alongside the pertinent issues raised by the Open University Human Ethics Committee. This chapter ends with a discussion about how the quantitative and qualitative data were analysed and a discussion of how the two types of data were brought together to create the findings to this research.

Chapters five to eight present the findings that have emerged from the research. Chapter five provides an overview of respondents discussing key variables and interrogating respondents' attitudes towards relationships. In chapter six, respondents' reported risk-taking, and how they contextualise this within a wider masculinities discourse, is examined. This chapter also examines seronegative respondents' understandings of their HIV risk from high-risk sexual activity and from seropositive men. Chapter seven examines the moral discourses that are present in the data and how this has given rise to a discourse of an '*other*', with whom respondents can compare their own risk-taking in order to sanitise these behaviours. In addition, this chapter examines the various ways in which respondents justify their own previous high-risk behaviours to ensure they do not become labelled as an '*other*'. In chapter eight, a discussion of the various aspects of the negotiation process takes place, examining issues around disclosure, the non-verbal nature of the negotiation process and the outcomes of this process in the form of the utilisation of condoms or the various risk reduction strategies.

Chapter nine draws together and discusses the findings presented in the previous chapters of the thesis. Key themes are discussed and links with the existing literature are made. Commencing with an examination of respondents' understandings of HIV risk and how relationship structures impact on this understanding, this chapter is structured around the

various stages of the negotiation process, culminating in a point where decisions are made about condoms or the use of a variety of risk reduction strategies.

Finally, chapter ten pulls together the main findings of this research and discusses their various implications. The methodology used in this research will be discussed and suggestions will be made with regard to using this method for future research. Theories of sexual health promotion will be reflected upon and related to the findings. New approaches will be suggested, based upon the changing risk landscape that has evolved in the findings. Finally, the chapter will reflect back on the aims of the study, summarising the main arguments that have emerged from the research.

Chapter Two - Research Context

Introduction

It is important to outline the developing context in which this research takes place. Numerous changes have taken place over the last twenty years that have impacted on the lives of MSM in the UK. For the purposes of this research, these changes were broadly divided into two main categories; biomedical and social change, which overlapped and linked in certain ways. While the biomedical changes have been discussed in the introductory chapter, the focus of this chapter will be HIV stigma and the impact on the disclosure process. While open and honest disclosure of HIV status may be used as a means to negotiate sex, HIV stigma impedes on this process. In addition, the consequences of the new relationship structures in the MSM communities will be discussed. The introduction of civil partnership in the UK and the subsequent introduction of gay marriage in Great Britain⁷ during the course of this research meant that MSM had new opportunities to form relationship structures that they had previously been unavailable to them. This discussion will situate the research within a broader social context that is likely to impact on the findings.

HIV-stigma and Disclosure

Even with the optimism presented by the developments of antiretrovirals for both the seropositive and seronegative communities, HIV stigma remains central to the experiences of many seropositive men. Earnshaw & Chaudoir (2009) identified a number of potential impacts

⁷ Although marriage is currently open to gay people in England, Scotland and Wales, civil partnerships currently remain the only option for gay people in Northern Ireland. The most recent attempt to pass such a law in the Northern Ireland Assembly in November 2015 was supported by the majority of MLAs (Members of the Legislative Assembly), but blocked by the Democratic Unionist Party who used a 'petition of concern' to argue that the law would not have sufficient cross-community support. It is likely that this result will now be challenged at the European Court of Human Rights (McDonald, 2015).

that stemmed from HIV stigma for seropositive individuals including job loss, social rejection and/or physical violence. However, Nyblade & MacQuarrie (2006) have also documented the impacts of HIV stigma on prevention, care and treatment outcomes on a community, individual and PLHA level:

‘Fear of and actual experience with stigma and discrimination reduce an individual’s willingness to practice prevention, seek HIV testing, disclose his or her HIV status to others, ask for (or give) care and support, and begin and adhere to treatment.’

(Nyblade & MacQuarrie, 2006, 2)

While HIV stigma was most prevalent during the early years of the AIDS crisis, Stangl et al. (2013) identified a significant reduction in the stigma-reduction field throughout the world over the decade from 2002-2013. Nevertheless, while optimistic about the improvements made, they identified a need for more multi-faceted approaches to HIV stigma to tackle ‘multiple stigma domains at multiple levels’ (Stangl et al., 2013, 18744) emphasising the need for continued interventions at national levels to tackle the effect of the multiple layers of HIV stigma and their outcomes.

In order to understand the nature of HIV stigma, I have turned to Goffman’s (1968) theory of stigma to investigate the causes and discrimination an individual may have experienced as a result of such a label being applied. Goffman (1968) first coined the term stigma to refer to an attribute that discredited a person or prevented them from full acceptance in certain social situations. He emphasised the difference between the ‘virtual social identity’, the stereotypes people created about others and the ‘actual social identity’, which were the attributes the individual possessed. According to his theory, it was when a discrepancy arose between the virtual and social identities, that stigma occurred. However, experiences of stigma may have depended on whether or not the individual was discredited, where the stigma was discernible,

or discreditable, where the stigma was not immediately visible to the naked eye (Goffman, 1968). Those who were discreditable could engage in 'passing', which Goffman described as a routine to avoid detection. However, there was a significant emotional cost to 'passing', as people constantly lived in fear of being discredited (Barry & Yuill, 2008). In their study of epilepsy, Scambler & Hopkins (1988) further developed Goffman's theory by differentiating between enacted and felt stigma. According to the authors:

'enacted stigma refers to instances of discrimination against people with epilepsy based on the perception of them as somewhat unacceptably different or inferior...[while] felt stigma refers principally to the fear of meeting with enacted stigma, although it also embraces a sense of shame that frequently attends 'being epileptic'.'

(Scambler & Hopkins, 1988, 156-157)

While enacted stigma was the discrimination that people with the stigma experienced, felt stigma was the fear of enacted stigma. In their study, Scambler & Hopkins (1998) found that felt stigma was more disruptive to the lives of epileptics than enacted stigma. This suggested that many people who never experienced discrimination based on their stigma, and/or who were discreditable, lived with an internalised sense of shame and the fear of rejection and discrimination.

One of the primary criticisms of how Goffman's work has been developed was the focus on the individual rather than the social level (Gilbert & Walker, 2010). The micro analysis suggested that instances of stigma were produced during face-to-face interactions and tended to be understood in emotive terms. However, more recent analysis by theorists, such as Parker & Aggleton (2003) and Scambler (2006), emphasised the social nature of stigma and contended that:

‘stigma and stigmatisation function, quite literally at the point of intersection between culture, power and difference – and it is only by exploring these different categories that it becomes possible to understand stigma and stigmatisation not merely as an isolated phenomenon, or expression of individual attitudes or of cultural values, but as central to the constitution of the prevailing social order.’

(Parker & Aggleton, 2003, 17)

Integrating structural theory with Foucault’s work on governmentality (discussed later in relation to risk), Parker & Aggleton (2003) suggested that stigma became a changing and sometimes resisted social process, rather than a static attitude. Therefore, it was quite conceivable to imagine stigma as a reflection of the prevailing social order rather than individual self-expression. Social actors who wished to maintain their hegemony in society influenced stigma to legitimise the existing structures of social inequality (Parker & Aggleton, 2003). From this assessment, stigma reinforced the established norms in a society. For example, it could be suggested that the conservative political establishment that dominated Western society during the emergence of AIDS in the 1980s may be understood as manipulators of the crisis by placing emphasis on the ‘*deviant*’ nature of homosexuality, suggesting that MSM were responsible for their own illness. According to this social perspective, the subsequent stigmatisation of people with AIDS was a reflection of the existing social structures rather than individual reactions.

Goffman’s theory and its subsequent developments, have been applied to the field of HIV/AIDS. Botnick (2000) reported that a solidarity existed in MSM communities at the beginning of the AIDS crisis, as all MSM were either *infected* or *affected* by a virus that potentially endangered the lives of everyone in the communities. However, Botnick (2000) also noted a subsequent breakdown in unity with the emergence of HIV-antibody testing. This new awareness of serostatus leaked into conservative discourses about the ‘innocent’ victims of HIV/AIDS

(children, haemophiliacs etc.), with the result that those MSM who were subsequently diagnosed with HIV were seen as 'guilty' for breaking the condom code. The initial divisions that arose within the MSM communities led to, what was known then as, aidsphobia, the predecessor to HIV stigma. Botnick (2000) suggested that seronegative men became further isolated from their seropositive peers as resentment grew when more and more funding was redirected away from community based projects towards AIDS organisations. Consequently, 'someone with a positive serostatus [became] viewed as a fully-fledged member of the gay community and a person of negative serostatus [was] viewed as inferior and marginalised' (Botnick, 2000, 58). Flowers (2001) also identified further divisions within the seropositive communities as a result of the introduction of detectability testing in the late 1990's, in which seropositive men could be divided into those who were undetectable and detectable (the infectious). In his study of the subjective meanings associated with serostatus prior to the existence of antiretrovirals, Johnston (1995) found clear divisions in how serostatus was understood by gay men with words such as *dirty*, *promiscuous*, *slut* and *reckless* associated with a positive serostatus. These terms suggested the manifestation of a strong moral dimension to HIV/AIDS within the MSM communities.

The emergence of antiretrovirals for use on seropositive men has meant that many of the physical demarcations previously associated with AIDS are no longer visible on many seropositive men (Scandlyn, 2000). While a number of seropositive men still suffer lipodystrophy as a side effect of taking antiretrovirals (discredited), many have no visible sign of infection (discreditable). Aidsphobia has now been replaced by HIV stigma, which UNAIDS (2003, 1) defined as the 'process of devaluation of people living with or associated with HIV or AIDS...Discrimination follows stigma and is the unfair or unjust treatment of an individual based upon this *real or perceived* HIV status' (emphasis my own). Stirratt (2005) has identified a variety

of consequences of HIV stigma for seropositive men, most notably sexual rejection. Recent research in the UK has shown that almost every seropositive respondent experienced rejection from potential sex partners when status was revealed, yet they also feared prosecution for reckless transmission if they did not disclose (Bourne et al., 2009). Other forms of rejection associated with HIV stigma identified by Stirratt (2005) included emotional or relationship dissolution and, in more extreme cases, violence. Drawing on Goffman's (1963) courtesy stigma⁸, Walker (2007, cited in Gilbert & Walker, 2010) found that many seronegative men who associated with their seropositive counterparts were 'stigmatised-by-association', which indicated that HIV stigma could also be applied to those who did not carry the virus. Consequently, many seropositive men 'self-stigmatise' (Akande, 2010, 559) by becoming reluctant to disclose their status and engaging in serosorting to screen potential partners. In this manner, some seropositive men can engage in high-risk behaviours, such as barebacking and drug use, without fearing the consequences of rejection or infecting others, which Kelly et al. (2009) have identified as a means used by some men to cope with their HIV diagnosis.

However, HIV stigma also existed within the seropositive community itself. Bogart et al. (2007) used the concept of 'stigma layering' to account for the variety of stigmas that seropositive men experience. Therefore, experiences of stigma had multiple dimensions and/or depend on other factors such as detectability, co-infection etc. For example, Dodds (2006) identified HIV-related stigma and discrimination based on age with older seropositive men being described as 'benefits queens' by their younger counterparts. In turn, younger seropositive men felt judged by older men, as they had HIV education and services and should have been more *responsible* in avoiding infection. In addition, while some research suggested that seropositive men were more likely to associate mainly or exclusively with other seropositive men (Botnick, 2000), others actively

⁸ Courtesy stigma is stigma that is attached to a person who is associated with the stigmatised person (Goffman, 1963).

sought to distance themselves from seropositive men, who they considered to be morally inferior. As a seropositive respondent to Bourne et al. (2009) stated:

‘But if you ever went in to gaydar and you went, and you did a sort of positive, putting HIV positive as a search, you tend to come up with sort of a certain type of gay man who is giving the impression of being very promiscuous and being into just about, you know, everything.’

(Bourne et al., 2009, 22)

Thus, there was a desire among some seropositive men to differentiate themselves as a socially responsible actor as opposed to the irresponsible other, reinforcing the established stigma that existed outside the seropositive communities.

Taken together, the stigma felt by, and within, the seropositive communities has wider consequences for sexual health promoters. Sayles et al. (2009) found that men who experienced high level of stigma were over twice as likely to have difficulties with treatment adherence and five times more likely to report poor access to medical care. Therefore, the likelihood of these patients achieving and maintaining an undetectable viral load was significantly reduced. Equally, HIV stigma impacted upon levels of testing, as seronegative/status unknown men may have avoided testing because of the negative social consequences of a positive test result (Feng et al., 2010). Studies on men and women from seven sites from across the US have also suggested that HIV stigma was strongly associated with a decreased likelihood of testing for HIV (CAPS, 2006). Examining a range of HIV stigma interventions throughout the world, Pulerwitz et al. (2010) found that testing practices increased significantly after the interventions. This research included a variety of people from various occupations and found that health care workers were more likely to engage in testing after the interventions. In their study of Scottish men, Flowers et al. (2000) found that the othering of seropositive men impacted upon seronegative men’s

desire to test for HIV, particularly when an unknown status was often equated with a seronegative one. Therefore, there was little motivation for these men to test for HIV.

Testing continues to be a major source of concern for sexual health promoters. Recent research has estimated that 54.9% of MSM in the UK were testing annually, while only 26.7% of those engaging in high-risk sexual activities were testing every three months (McDaid et al., 2016). In addition, rates of late diagnosis remained stubbornly high with over 1,100 MSM diagnosed with a CD4 count of <350 (Skingsley et al., 2015a). In addition to potentially infecting others when unaware of their own infection, those diagnosed at a later stage also had greater difficulties managing their antiretrovirals and maintaining an undetectable viral load (Schwarcz et al, 2006). Therefore, ensuring regular testing and reducing stigma remains a vital concern in the UK context. While there is no doubt that other factors play a role in why MSM do not test more regularly, such as not perceiving themselves to be at risk of HIV (Health Protection Agency, 2011), it was clear that HIV stigma may play a significant role.

HIV stigma may also impact upon seropositive men's decisions about whether or not to disclose their serostatus to other men. In research carried out by Ridge et al. (2007), many seropositive men expressed a desire to tell their partners of their serostatus prior to sex, as not doing so was understood as detrimental to one's mental health. However, as discussed, the consequences of disclosure were manifold for seropositive men. As Smit et al. (2012, cited in Murphy et al., 2015b, 431) pointed out, 'HIV is heavily stigmatised in gay communities, inhibiting disclosure'. Indeed, it may be that, because of an undetectable viral load, many seropositive men felt that it was not in their interests to disclose their serostatus given the significantly reduced risk they posed to other men, particularly when they did not engage in unprotected anal sex (Newcomb et al., 2016). However, if a seropositive man chose this option in the sexual encounter, it may

be interpreted as denying his seronegative partner's right to choose what risk was acceptable to him (Keogh, 2008). From this perspective, seropositive men had a responsibility to disclose their serostatus to their partners to ensure they had knowledge of the risks they were taking. However, if seronegative men held the belief that seropositive men had a responsibility to disclose, they were also likely to assume that their partners were seronegative unless they disclosed (Flowers et al., 2000). This further increased the possibility of HIV transmission in such cases.

Research on seropositive men also suggested that there were several perceived barriers to disclosure. These included rejection/missed sexual opportunities, confidentiality, partner's assumed serostatus, deferred responsibility, sexual partner type and public sex environments (Driskell et al., 2010). Even with these barriers to disclosure, almost two-thirds of seropositive men felt it was their responsibility to inform their partner of their serostatus to protect them from becoming infected (Wolitski et al., 2003). However, one quarter of these respondents felt that it was the responsibility of both partners to disclose, suggesting that seronegative men shared at least some responsibility for protecting themselves, while the remainder felt that responsibility lay solely with their partner. This suggests that seropositive men took most of the responsibility for disclosure of serostatus when having sex with other men. However, those who met their partners in public sex environments and/or those who believed there was little risk of transmitting the virus through specific sexual activity were least likely to believe they had a responsibility to disclose to their partners (Wolitski et al., 2003). Therefore, while the majority of seropositive men felt that it was their responsibility to disclose their serostatus to their partners, this was often dependent on their own interpretation of risk. However, given the significant changes and new knowledge about infectiousness that have arisen since Wolitski et

al. (2003) wrote their article, it may be that seropositive men now feel less responsible for disclosure than previously.

In comparison to the abundance of literature carried out on seropositive men about disclosure, little research has explored seronegative men's disclosure expectations. It is probable that the laws regarding HIV disclosure in some jurisdictions (currently not in the UK⁹) reflect the extent of literature produced. Disclosure by seronegative men was also problematic in that it only reflected the result of their last HIV-antibody test, which may not necessarily be a definitive indicator of their current serostatus. Research from Australia indicated that similar rates of seropositive (47%), seronegative (54%) and untested MSM (45%) disclosed their serostatus prior to having anal sex with their last casual partner. However, in a similar way to their seropositive counterparts, seronegative men in this research were significantly less likely to report disclosure in public sex environments (Holt et al., 2011). This research suggested similar patterns of behaviour among all three groups of men when it came to disclosure. More recent research also from Australia also indicated that three-quarters of seronegative men expected seropositive men to disclose their serostatus prior to engaging in sex implying that a 'disclosure double standard' exist among seronegative men:

'...whereby they [seronegative men] have high expectations that HIV-positive men disclose their HIV status and much lower expectations that HIV-negative men (i.e. men similar to themselves) disclose their HIV status. This discrepancy suggests that

⁹ Currently, the law in Scotland indicates that a seropositive person can be prosecuted if they put someone 'at risk' of HIV acquisition through unprotected sex. However, the term 'at risk' is open to interpretation. The law in the remainder of the UK relates to reckless transmission, whereby HIV must be transmitted from one person to another, in order for a successful prosecution. Disclosure of serostatus can mitigate a seropositive person's responsibility in all countries of the UK. Further discussion of the law is in the methodology chapter.

the default expectation of these HIV-negative and untested men is that a partner is HIV-negative unless he says otherwise.’

(Murphy et al., 2015a, 96)

However, research that has emanated from the UK has indicated that those seronegative men who had greater proximity to HIV (i.e. who knew someone who was seropositive) were less likely to expect seropositive men to disclose their serostatus and had a better understanding of how to deal with such a disclosure than other seronegative men (Keogh, 2008). They were also significantly less likely to talk about seropositive men in moral terms than others. However, Murphy et al. (2015a, 91) concluded that given the prevalence of HIV stigma in the communities:

‘Rather than being part of specific strategies to reduce the risk of HIV through limiting condomless sex to partners they believe share the same HIV status, some disclosure expectations and practices may be part of a strategy [of seronegative men] to avoid HIV-positive men as sex partners altogether.’

This suggested that seronegative men might have used techniques of HIV risk reduction to justify their avoidance of all sexual contact with seropositive men.

New Relationship Structures – Civil Partnerships and Gay Marriage

During data collection, a change in law meant that the institution of marriage became available for the first time to gay men and women in Great Britain¹⁰. Although civil partnerships had been available to gay people for several years, this law meant that homosexuals were placed on an equal legal footing with their heterosexual counterparts with regard to relationship recognition.

¹⁰ Many gay men and women have availed of heterosexual marriage in the past for a variety of reasons. However, this was the first occasion when gay couples of the same sex could marry each other.

However, the journey to that point has been a long one. While British law has moved far from the death penalty imposed on certain kinds of homosexual conduct during the sixteenth and seventeenth centuries (Burg, 1981), renowned cases such as the Marquess of Queensbury vs. Oscar Wilde remind many gay people of a dark past. In 1953, over two thousand men were imprisoned for indictable homosexual offences in the UK and it was suggested that many others succumbed to blackmail or commit suicide rather than face the disgrace of exposure (Cretney, 2006). Even after the decriminalisation of homosexuality in 1967, the introduction of Section 28¹¹ by Margaret Thatcher twenty years later at the height of the AIDS crisis reinforced an established conservative, anti-homosexual discourse among the British public.

‘We are reaping what was sown in the sixties...fashionable theories and permissive claptrap set the scene for a society in which old values of discipline and restraint were denigrated.’

(Margaret Thatcher 1982, cited in Marwick, 1998, 4)

These relatively recent laws and discourses reflected the difficult path to marriage equality. However on a more positive note, the new millennium also saw the repeal of Section 28 (2000 in Scotland; 2003 in the rest of the UK) and the equalising of the age of consent between homosexuals and their heterosexual counterparts (Waites, 2003). The Civil Partnership Act 2004, a precursor to gay marriage, became law on 5th of December 2005 allowing gay people many of the rights associated with heterosexual marriage. Up until the end of 2013¹², 66,730 couples in the United Kingdom had entered a civil partnership, fifty-four percent of whom were male (ONS, 2015a). It is likely that the number of people now entering civil partnerships will

¹¹ Section 28 of the Local Government Act 1988 stated that ‘a local authority shall not (a) intentionally promote homosexuality or publish material with the intention of promoting homosexuality; (b) promote the teaching in any maintained school of the acceptability of homosexuality as a pretended family relationship’ (cited in Bell & Cumper, 2003, 215).

¹² Statistics for the number of civil partnerships in the UK in 2014 have yet to be published at time of writing. Statistics for England and Wales in 2014 have been published, but for consistency, only UK figures are included here.

decline as more people opt for gay marriage. Recent research has shown that in the first six months since the introduction of gay marriage, there were twice as many conversions from civil partnerships to gay marriage as 'new' gay marriages (Elgot, 2016).

However, the introduction of these formalised relationship structures in the MSM communities has led many queer theorists to question what Neary (2014) refers to as 'the normalisation project'. This project is an ongoing one in which gay men and women are situated, whether or not they have interest in gay marriage¹³ for themselves. However as Croce (2015, 15, *emphasis author's own*) pointed out, this process 'does not simply *permit* homosexuals to form unions, but seeks to make them *desire* to form unions'. Therefore, the ongoing objectives of the normalisation project are twofold; to give rights to gay people to marry, and to make gay marriage a desirable institution for them to invest in. As part of this process to make marriage desirable, much of the gay marriage debate has been embedded in equality discourses, which are 'profoundly attuned with the neoliberal concept of autonomy' that currently dominates British and Western political thought (Ammaturo, 2014, 176). However, it is the contention of many queer theorists and feminists that these equality discourses, which have accelerated the introduction of formalised relationship structures for gay people, have not challenged the heteronormative institution of marriage and have 'facilitated the workings of disciplinary power in ways that individualises, privatises, normalises and (re)produces the ideal, heteronormative citizen' (Neary, 2014, 48). Many such theorists argued that this was a marked change from a time when gay men and women resisted the institution of marriage, from which they had previously been excluded. In acknowledging this change, Duggan (2002) coined the term

¹³ From this point on, the term 'gay marriage' is used to represent any formalised legal gay relationship structure, be that marriage or civil partnership.

'homonormativity' to signal the radical difference between the liberationist politics of the 1970's and the assimilationist approach currently dominating the queer movement.

The movement from resistance towards normalisation was likely to have created divisions within the gay communities in which some relationship structures were seen as desirable, while others were deemed less so. In this process, those who formed long-term monogamous relationships and were bound to them through the institution of marriage became idealised, while those who rejected or resisted were illegitimatised.

'Social tolerance and legal equality discourses foster the incorporation of some gay men and lesbians into the mainstream of neoliberal, heteronormative citizenship at the expense of others whose gender or sexual identities or practices cannot be so easily tolerated...Sexuality is privatised and domesticated with long-term monogamous coupledness emblematic of 'good' gay citizenship and other forms constituted as morally weaker or personally less fulfilling.'

(Duncan et al., 2015a, 800, emphasis authors' own)

This drive towards the "good gay citizen" narrative (Bell & Binnie, 2000) within the gay marriage movement made gay men and women more acceptable to their heterosexual counterparts. However, to become normalised to the heterosexual eye, gay couples had to replicate heterosexual conventions, with the result that they neither fully occupied the straight or the queer worlds.

'While same-sex couples gain social acceptance, they get along famously with the heteronormative tradition and create the identity of 'a good homosexual', the ones that can be invited to dinner, social gatherings and so on. Marriage is considered healthy and normal while singles are treated with suspicion...in this revised social

order gay people are, of course, not straight; but then, they are not necessarily queer either.'

(Patra, 2015, 70)

This suggested that in order to become legitimatised gay couples, gay men and women had to assimilate to heterosexual norms and behaviours and differentiate themselves from the 'bad gays' in order to be fully accepted. However, when they did so, they occupied a space that was neither fully heterosexual nor homosexual.

In her comparison of gay marriage with the now dated law of seduction, Murray (2012) employed the example of marriage that was used as a form of punishment for a criminal offence in the nineteenth century to illustrate the effect that gay marriage may have had on the MSM communities. She contended that the primary purpose of imposing marriage as a form of punishment for the crime of seduction was to brand sex outside of marriage as illegitimate. By applying this example to the current discussion, Murray (2012, 24-47) maintained that gay marriage legitimised sex between the disciplined gay married couple and isolated those who were single, and those who did not engage in 'ordinary' sex, who are defined as deviant and dangerous.

'Seduction contributed to a culture of sexual license, where men were free to engage in illicit sex outside marriage, thereby compromising marriage's role as the locus for sexual activity. If marriage served as the licensed site for sexual expression, then the space outside of marriage was one stained with the taint of deviance, criminality and danger...[The] transformation of same sex-sodomy into marriage-like intimacy not only reflects marriage's disciplinary force, but also underwrites an effort to impose some kind of discipline in the interstitial space between marriage and crime.'

Therefore, while those who did not enter into the institution of marriage were no longer engaging in illegal activity, the introduction of the institution in the MSM communities might have disciplined those who lie outside it. Therefore, sexual hierarchies were created in which those who engaged in sexual activities that were not deemed conducive with marriage's norms were stigmatised, while those who embraced these norms were legitimatised. In her discussion about the prospect of gay marriage's introduction in the United States, Butler (2002) questioned if these new hierarchies would create moral judgements within the gay communities between those who did not wish to and/or could not engage with this new legitimate form of sexual arrangement and those who embraced marriage. Given the need for 'good' gays to distinguish themselves from 'bad' ones, it was possible that such hierarchies were created by the moral judgements discussed by Butler. From this perspective, marriage was more likely to further divide the MSM communities rather than unite them.

While it is too early to say if the introduction of gay marriage and/or civil partnership have led to these hierarchies, early indications from research suggested that those in these relationships often embraced conservatism and compared their own relationships to other heterosexual sexually-exclusive marriages. In their research, Heaphy et al. (2013, 3-4) found that younger couples who had entered civil partnerships:

'tended to invest in the couple as the ideal relational form, linked monogamous relationships to maturity, drew on their parents' and others' relationships to articulate their relational imaginaries and ceremonialised their 'marriages' in mainstream and sometimes self-consciously conservative ways. Compared to previous generations of same-sex relationships as reported by a number of studies, the younger couples we studied appeared to be more actively invested in convention rather than radical relational experimentation.'

However, as discussed later in the literature review, many gay couples negotiated open relationships, in which one or both partners agreed to have sex with other men, even within marriage. These relationship structures do not sit easily with the discussions of monogamy that many queer theorists and feminists have assumed will be the driving force of homonormativities. However, Duncan et al. (2015a) distinguished between the private and public aspect of relationships. It was their argument that as long as non-monogamy remained a private part of the publically recognised gay marriage, then it was consistent with neoliberalism and did not challenge the institution of marriage.

‘Providing non-monogamy is a private aspect of the publically endorsed, equal gay couple, it is fully consistent with the ideals of the neo-liberal state and with the sexual and social opportunities of the commercial gay scene.’

(Duncan et al., 2015a, 802)

Therefore, as long as gay men remained discreet about their open relationships within gay marriage and *appear* monogamous, they presented no threat to the conventions of gay marriage. As a result, while monogamy in gay relationships may be more complicated than presented in the ideological form discussed above, open relationships did not challenge the convention of marriage as long as it remained private.

Conclusions

Goffman’s theory of stigma (1968) has particular relevance to the field of HIV. The differentiation between ‘felt’ and ‘enacted’ stigma enabled us to understand people’s fear of discrimination and how this impacted upon their lives, even if they never encountered enacted stigma (Scambler & Hopkins, 1998). The development of HIV-antibody testing in the early years

of the AIDS crisis created divisions within MSM communities and led to aidsphobia, the predecessor to HIV stigma (Botnick, 2000). However, the emergence of antiretrovirals has meant that the physical demarcations associated with AIDS are no longer visible on seropositive men, resulting in rising HIV stigma (Scandlyn, 2000). Rejection was the most commonly reported consequence of HIV-stigma (Stirratt, 2005) and many seronegative men encountered stigma-by-association as a result of associating with their seropositive counterparts (Walker, 2007, cited in Gilbert & Walker, 2010). However, stigma also existed within the seropositive communities and stigma-layering resulted in multiple forms of stigmatisation (Bogart et al., 2007). Research has shown that seropositive men stigmatised others for a variety of reasons (Dodds, 2006; Bourne et al., 2009). The wider consequences of HIV stigma indicated that it impacted on seropositive men's ability to maintain an undetectable viral load (Sayles et al., 2009) and on seronegative men's testing for HIV (Feng et al., 2010). Therefore, there is a need to challenge the extent of HIV stigma within the MSM communities.

However, HIV stigma was also likely to impact on seropositive men's desire to disclose their serostatus prior to engaging in sex. While research has indicated that disclosure was important for seropositive men's mental health (Ridge et al., 2007), they also opened themselves to the possibility of HIV stigma as a result (Smit et al., 2012, cited in Murphy et al., 2015b). Nevertheless, the majority of seropositive men felt that it was their responsibility to disclose their serostatus to other men prior to engaging in sex (Wolitski et al., 2003). However, opinions about disclosure changed in public sex environments and/or when seropositive men felt that there was little risk of transmission during sex (Driskell et al., 2010). However, research on seronegative men indicated that, although they disclosed at a very similar rate to their seropositive counterparts (Holt et al., 2011), they felt it was the responsibility of seropositive men to disclose their status prior to sex (Murphy et al. 2015a). This has led to a double standard of disclosure that has led

some authors to question if this was used by seronegative men as a means of avoiding sex with seropositive men, rather than a genuine risk reduction strategy (Murphy et al. 2015a).

Exploring the context of this research was important, as it also drew out a number of important social changes that have affected the lives of MSM. The introduction of civil partnerships and gay marriage have created opportunities for gay men and women to aspire to new relationship structures previously unavailable to them. However, the embracing of the heteronormative institution of marriage is in stark contrast to the liberationist politics embraced by the gay movement in the 1970's (Duggan, 2002). The process of normalisation (Neary, 2014) that has occurred over the last twenty years has led some queer theorists and feminists to suggest that this process has created divisions within the communities (Butler, 2002) between those who lived up to the idea of the 'good' gay and those who did not (Bell & Binnie, 2000). Central to this was the legitimisation of sex within gay marriage and the demonization of single MSM and those who engaged in other transgressive activities (Murray, 2012). This created hierarchies within the gay communities between those who engaged in legitimate sex and those who were illegitimate, which was based upon moral judgements of others (Duncan et al., 2015a). This suggested that gay marriage, while creating coupledness, was also creating further divisions within the communities between those who wished to embrace marriage and those who did not wish, or could not do so.

Therefore, the context of this research is unclear. It is a time of great change in the MSM communities in relation to both sex and love. However, early research on the social effects of both developments suggested that the communities were in a state of flux. While these developments can be interpreted as primarily positive in nature, the full effect, and the impact

it may have on HIV stigma, has yet to be ascertained. It is in these exciting times of flux that this research is set.

Chapter Three - Literature Review

Introduction

This review sets out to investigate MSM's understanding of the risk of HIV infection at the current time. Initially, I turn my attention to focus on the difficulties faced by sexual health promoters in conveying the safe sex message to the MSM communities without seeming to pontificate (Doods, 2002). This balance is often a difficult to find and highlights the substantial complexities facing those trying to promote safer sex in a post-antiretroviral society. I will also discuss how various approaches to sexual health promotion have changed over the years since the beginning of the AIDS crisis (Doods, 2002; Coveney & Bunton, 2003; Lee, 2007). An examination of various theories of risk follows (Beck, 1992; Giddens, 1998; Lupton, 2006; Douglas 1985; Joffe, 2003; Foucault, 1978), in which I investigate how these theories help in the understanding of HIV risk. Ensuring that MSM understand their risk of HIV infection is one of the most important aspects of trying to combat HIV. However, in the section that follows, I explore the literature on how MSM judge and understand risk in a post-antiretroviral context, where the individual is encouraged to take responsibility for their own health (Lupton, 1994). This leads into a discussion on the role masculinities (Connell, 1995) play in MSM's sexual lives and how this may influence their choices when engaging in sex. It is in this discussion that I begin to discuss how risk, which is traditionally understood in the context of danger, can become something that is understood as exciting and pleasurable (Lupton & Tulloch, 2002). From this perspective, bareback sex may take on a transgressive nature as it becomes a way in which men can gain excitement from taking risks and escape the condom code, which some men may feel is being imposed upon them (Ridge, 2004; Dean, 2009). Therefore, it is not only the safer sex message that needs to be considered, but also the role masculinities play in MSM's sexual encounters. My discussion then turns to the nature and prevalence of open relationships in the MSM communities (Hickson et al., 1994; Whitton et al., 2015), which may also be a concern for sexual health promoters. While often seen as aiding the spread of HIV, many MSM see these

relationships as a way in which HIV risk can be minimised (Adam, 2006; Prestage et al., 2008). The honesty and openness, which MSM see as being central to open relationships (Hickson et al., 1994), is encouraged in the negotiation of all forms of safer sex. However, in the examination of how MSM negotiate safe sex, I find that much of the negotiation happens in a non-verbal manner, which may lead to confusion and misinterpretation between sexual partners (Persson et al. 2015; Delph, 1978). This is particularly true for serodiscordant partners who may have very different understandings of cues given. These challenges make the difficulties facing health promoters very difficult to surmount.

The challenges for Sexual Health Promoters

It is widely accepted that sexual health promotion has saved many people from becoming infected with the HIV virus since the 1980's. Johnson et al. (2002) measured the effectiveness of sexual health promotion on MSM and found the number of barebackers fell by 26% after a sexual health intervention. However, questions have been raised about how to make MSM more aware of interventions, with knowledge among key groups describes as 'poor' (French et al., 2014). It is possible that, as Numer & Gahagan (2009) suggested, mass media interventions need to be more representative of MSM's lived experiences, including barebacking, in order for them to reach men who would not traditionally engaged with such messages. During the early years of the virus, the focus of mass media HIV prevention interventions (MMI) was on providing stern, direct facts about the virus and information about how it was spread. However, Dodds (2002) observed a noticeable shift in such materials aimed at gay men throughout the 1990's. There was a move away from the harsh factual nature of MMI to a friendlier attempt to encourage men to consider safer sex and with providing negotiation phrases on how to assert this. However, with this move towards friendly encouragement, less importance was placed in

MMI on the facts about how HIV was transmitted (Dodds, 2002). While this approach tried to address the saturation of HIV facts within the MSM communities, it also presumed that MSM had established knowledge of the virus and how it was transmitted, which presented dangers for those who did not. In line with the neo-liberalist emphasis on individual responsibility, there was also a shift towards harm reduction, which invited readers 'to consider their own position and choices in relation to risk rather than instructing them how to act' (Dodds, 2002, 154). However, this choice was heavily laden with responsibility and the reader was left with no doubt that they were being strongly advised to follow the advice given (Lupton, 1994). While emphasis was placed on the notion of freedom, it was also closely tied to expectations of individual responsibility. Therefore, individual choice was heavily imbued with notions of moral responsibility and they were blamed if the 'wrong' decision is made (Lupton, 1994).

One of the central problems faced by sexual health promoters was how to promote sexual health in the face of alternatives that might be considered more satisfying and appealing. In their discussions of pleasure in relation to the health field, Coveney and Bunton (2003) explored the difficulties faced by those trying to promote a healthy lifestyle in the face of the pleasures of unhealthy ones. Pleasures, which are dominated by the emotions, were seen to contradict the rational thinking that prevailed within the medical profession and were seen as something that must be controlled for the sake of health. Elias (1982) stated that carnal pleasures were in constant battle with disciplined pleasures, which emerged from the tenets of Protestantism. Disciplined pleasure involved more rational, individualised thinking and the deferral of instant gratification. Older health promotion approaches placed emphasis on disciplined pleasure with its concentration on education and behavioural change (Ewles & Simnett 1995, cited in Katz & Peberdy 1998). Developments have placed emphasis on values such as self/community-empowerment and on social circumstances (French & Adams, 1986; Tones & Tilford, 1994).

However, more recently, carnal pleasure has become an issue for some authors proposing that sexual health promotion should endorse both disciplined and carnal pleasures. For example, Sandfort (2006, 232) stated that 'instead of focussing on prevention, sexual health promotion can also aim at enhancing positive health, which would mean increasing people's capacity to achieve sexual intimacy and have a joyful sexual life'. However, finding the correct balance between carnal and disciplined pleasure was challenging. As a result, MMI has been criticised for placing too much emphasis on carnal pleasure, which has been detrimental to the overall aim of the promotion (Lee, 2007, discussed later).

However, from an alternative viewpoint, pleasure was also seen as a point of resistance against the norms that public health tried to impose on free people: "pleasure thus can act as a rallying point or '*clarion call*' to oppose the forces of unwanted '*authoritarian*' control of individual choice, and the unwelcome incursion of expert reason into the life-world" (Coveney & Bunton, 2003, 166; emphasis authors' own). Not only were health promoters trying to endorse alternatives to what was seen to be as inherently more pleasurable, but they faced resistance from many who seen them as too controlling. Rofes (2002) suggested that this was particularly true for some of the MSM communities who have traditionally resisted powerful societal pressures to conform and he posed some profound questions about the effectiveness of any sexual health promotion in the communities:

'if resistance to health promotion is deeply rooted in the sexual subjectivities of a large proportion of gay men – and if resistance is linked to our production of ourselves as gender nonconforming and sexual outlaws – will *any* forms of health promotion serve to improve the health and wellness of gay men?'

(Rofes, 2002, 135, emphasis author's own)

However, Rofes (2002) assumed that MSM are a homogenous group of people who identify as transgressors and non-conformists. Indeed, while older men may have resisted societal expectations because of the legal and social discrimination they faced throughout their lives; many men born after that period became apathetic to the queer movement (Stein, 2012). Therefore, there may be more willingness to engage with health promotion than Rofes (2002) assumed.

In his analysis of MMI, Lee (2007) found that the tenets of advertising were being used to sell safe sex in *eXposed!* magazine produced by CHAPS¹⁴. He noted the overriding theme in the magazine was one of titillation and pleasure with sex-laden imagery dominating throughout. The setting of the images, in bars, clubs, bedrooms etc. reproduced the hedonistic lifestyle associated with the gay scene and the men presented were young, able-bodied, attractive, fit and sexually active. These representations only accounted for a minority of MSM, which Lee suggested, may be isolating for those who did not relate to these images. Crucially, he noted the complete absence of condoms in these images, which 'raises questions as to why it is difficult in sexual health promotion aimed at a gay audience to show safer sex practice but not difficult to show the most intimate unsafe sex acts...[that] may provoke a desire for sex, safe or unsafe' (Lee, 2007, 214-215). The irony was that such MMIs may have produced the desires and activities that sexual health promoters tried to diminish, creating difficulties for those promoters who used advertising tenets to capture their audiences' attention. These findings raised important points about the heterogeneity of MSM communities and the need for MMI to address wider audiences, without necessarily following the tenets of advertising. However, more recent research by Iantaffi et al. (2015) suggested that men held different opinions about

¹⁴ CHAPS: Community HIV/AIDS Prevention Strategy. A combination of a variety HIV/AIDS organisations and the Department of Health that agreed to collaborate in 2000 to provide a coherent approach to health promotion, under the management of the Terrence Higgins Trust (THT). Each year, CHAPS produced a SHP magazine called *eXposed!*.

sex-laden MMI according to location. While respondents to their research were resistant to the notion of using sexual imagery in MMIs, they felt that they may have been more appropriate for certain locations, such as saunas, certain bars etc. This indicated a difference in opinion between what is acceptable in the public (for general public consumption) and private (areas frequented predominantly by MSM). This division may have been caused by respondents associating sex-laden imagery with 'promiscuity and kinky sex, behaviors [sic] that are seen as counter to homonormativity' (Iantaffi et al., 2015, 1355).

Davies (2008) has pointed to the importance of altruism, particularly in messages targeting at the seropositive communities. These messages tended to focus on encouraging seropositive men to avoid HIV transmission to sexual partners. However, it may have also reinforced the idea that seropositive men were responsible for sexual safety in their encounters. Davies noted that blame for barebacking behaviours was usually apportioned to seropositive men in such messages.

'The altruistic imperative is however fused with the idea of the unruly individual. In particular, the idea of barebacking draws attention to those sexual actors whose behaviour reflects a kind of negative altruism, a denial of civic duty or a 'shrugging off' of obligation'.

(Davies, 2008, 183, emphasis author's own)

Therefore, it was possible that MMI may have been contributing to the shaming of seropositive men and shifted the balance of responsibility for safer sex onto seropositive men (Davis, 2008). This may have further isolated a group of men who were in need of the messages provided by sexual health promoters.

There are a wide variety of health promotion theories, many of which had diverse study populations, were multi-component in nature and varied in their implementation and effectiveness (Jackson & Waters, 2005). While many of these theories have been applied to various health settings, several specific difficulties surfaced in relation to MSM and HIV. This was particularly important given NICE¹⁵ recommended that techniques used in behavioural interventions should meet the individual's needs (NICE, 2014). Therefore, characteristics of MSM should have been considered when theories of health promotion were constructed. Traube et al. (2011) have highlighted three such difficulties with the applicability of health promotion theories to the field of HIV-related research:

‘(1) a large number of competing health theories; (2) the primacy of a few select theories in the absence of empirical evidence of their success in predicting behaviour [sic]; and (3) the improper translation of behavioural [sic] health risk theory to disparate populations.’

(Traube et al., 2011, 663)

Nevertheless, as these authors suggested, each individual theory had its own merits and limitations and it was possible that only a combination of various elements of each theory would have led to a successful overarching health promotion theory that incorporated the various environmental, social and psychological factors relevant to this field.

The Health Belief Model (HBM) was developed by social psychologists in the 1950's (Nettleton, 2006). The focus of the HBM was on the individual's motivation, or lack thereof, to take preventive action against a perceived health risk. The HBM asserted that when an individual perceived that they are vulnerable to threat, and understood that it had serious consequences,

¹⁵ National Institute of Clinical Excellence

they then took action based upon a balancing between benefits and costs. Outside stimuli, such as health messages, were required to make the individual aware that they were at risk and, based on this knowledge, they acted to protect themselves. Since then, the HBM has been further developed to incorporate cognitive theory and self-efficacy (Rosenstock et al., 1988; cited in Kemm & Close, 1995). These developments paved the way for the creation of the AIDS Risk Reduction Model (ARRM) (Catania et.al. 1990). The three stages of the ARRM were: '(a) recognising and labelling one's sexual behaviour as high-risk for contracting HIV, (b) making a commitment to reducing high-risk sexual behaviours and increasingly low risk activities, and (c) seeking and enacting strategies to attain these goals' (El-Bassel et al., 2001). However, in his study of risk behaviour among male prostitutes, Bloor (1995b) found that the HBM had limited applicability to HIV as it focused on the individual, ignoring that sexual encounters involved more than one person and are a social, rather than individual, activity. The same criticisms have been levelled at the ARRM. Both also presumed that once one was aware of the high-risk activity, there was a commitment to stop such behaviours. Neither could explain why barebackers who employed risk-reduction strategies, which indicated an awareness of the threat of HIV infection, ignored health messages and decided on alternative courses of action. As Numer (2014, 36, emphasis author's own) suggested, 'public health is often less well equipped to manage conscious engagement with risk behaviours and regulates individuals who do so to the status of "irrational"'.

The Transtheoretical Model, also known as Stages of Change Model (SoCM), was developed by Prochaska & DiClemente (1984) to acknowledge the processual nature of behaviour change. Unlike the HBM, SoCM listed several stages through which one progressed to successfully change a behaviour. Rather than a single event, behavioural change was seen as an on-going process in the SoCM, through which the individual progressed depending on their levels of

motivation or readiness to change (Nutbeam, 2006). The first stage, precontemplation, was when the individual was unaware of potential risks, or was consciously making a decision not to change their behaviour. For example, a barebacker who was aware of the potential risks to his health, yet was unable to commit to safer sex, may be in the precontemplation stage. The contemplation stage followed in which one became aware of the benefits of change and considered making such changes. According to Naidoo & Wills (2009), individuals remained at this stage for a short period of time, or never progressed beyond this stage. When one left the contemplation stage, they progressed to preparation, in which they made a commitment to change their behaviour. Here they became aware of the cost and benefits of behavioural change and may have begun to seek support that enabled them to make changes. The final two stages were action and maintenance, in which the individual began to change and maintained their new behaviour. However, acknowledging that change was not a smooth process, the SoCM accommodated relapse, in which the individual who reverted to their previous behaviour may have been sent back one, or several, stages (Jack et al., 2010). This was particularly important given that Bandura (1994, 46), in his research on preventing the spread of HIV, found that 'it is not unusual for some individuals to lapse into risky practices after having adopted safer ones'. In their later writings, Prochaska et al. (1994) also included a final stage of termination, in which the individual had changed their behaviour and had no desire to return to their previous behaviour. More recently, DiClemente (2005) emphasised the influence of the internal and external environments that surrounded the behavioural change. These environments may have significantly influenced how individuals progressed through the model. For example, if one used crystal meth in the company of others, they may find it more difficult to reduce bareback sex due to the environment they were in. While research has shown that individuals do move across the continuum of the SoCM model after an HIV intervention (UNAIDS, 1999), the model has been widely criticised by others. According to Nutbeam et al. (2010), SoCM failed to take

account of the full complexity of the behavioural change process, while Wills & Earle (2007,136, emphasis their own) stated that:

‘there are ethical concerns that application of the model leads to categorising people with as appropriate for interventions or ‘not ready’, thus exacerbating existing inequalities, as individuals in the latter category are likely to be those who are already least able to access the social, cultural or economic resources and support to make changes to their behaviour.’

Therefore, while SoCM incorporated the ongoing nature of the behavioural change process and allowed for relapses in behaviours, it has been criticised for not acknowledging the full complexity of the behavioural change process and may have further isolated those who did not pass the precontemplation stage.

On the other hand, the Situated Rationality Approach [SRA] (Bloor, 1995b) suggested that people made rational decisions based upon their definition of the situation they were in. For example, some MSM couples used condoms when they engaged in extra-dyadic encounters, whilst barebacking with their primary partner (Guzman et al. 2005). However, this focus on the rational thinker ignored the distinctions between the *irrational pre-sex self* and the *rational after-sex self* presented in much of the modern MMI (Keogh, 2001). Given the nature of sexual arousal, individuals may not be as reflective as they usually are and therefore, their ability to make rational choices may be impaired. Gerrard et al. (1996, 400) pointed out that “the unique nature of the sex drive contributes to the fact that decisions about sex are oftentimes made in the heat of the moment - when the person is emotionally and physically aroused - rather than after careful, or even rational, deliberation” (cited in Bancroft et al., 2003, 556). Maisto & Simons (2016) believed that it was these ‘heat of the moment’ decisions that still needed to be addressed in MMI. Other factors such as drug and alcohol usage also affected an individual’s

ability to make rational decisions. Research from the United States suggested that binge drinking was higher among MSM than men in the general population and that those who engaged in binge drinking were 33% more likely to have engaged in repetitive bareback sex (Hess et al., 2015). Therefore, to be expected to engage in rational, critical reflection at moments of sexual intensity and/or under the influence of alcohol or drugs, as the SRA suggested we should, was often unrealistic and disrupted the *natural* flow of sexual contact. In addition, the SRA ignored power imbalances between partners in sexual encounters and did not consider the habitual nature of some behaviour (Bloor, 1995b).

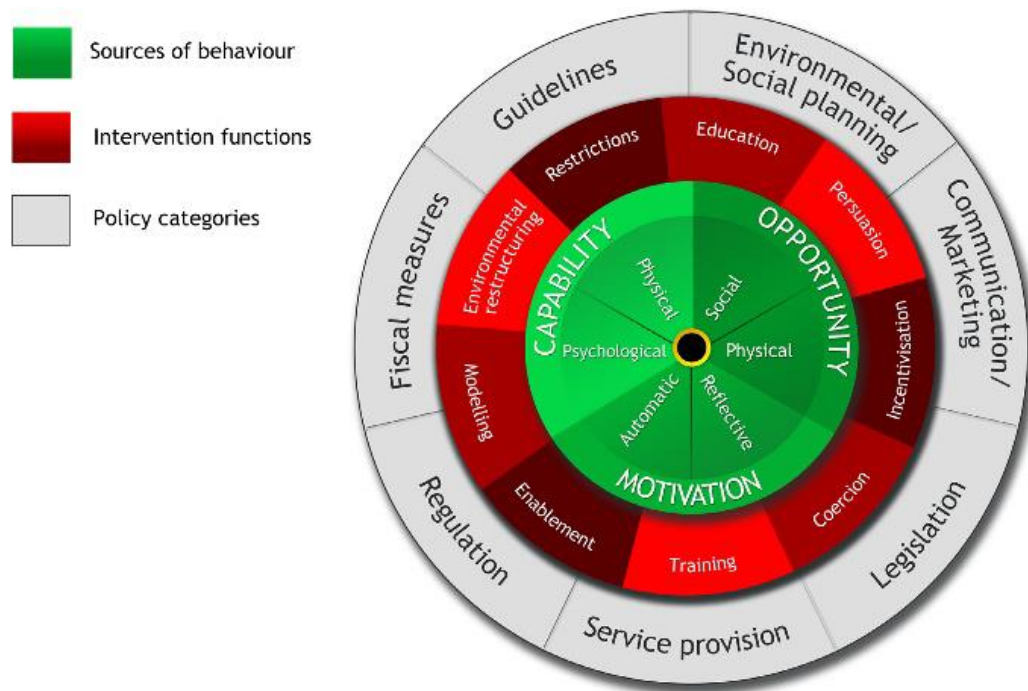
Douglas and Chavez's (1990) Cultures of Risk (CoR) suggested that risk behaviour and response was 'the product of differential socialisation in various subcultures and social institutions' (cited in Bloor, 1995b, 24). CoR created a grid with four boxes divided by the group axis and grid axis. The group axis represented how much the individual was integrated in bounded groups, while the grid axis represented the degree to which these groups required adherence to rules of conduct. However, while CoR attempted to address the variation within the MSM communities, its discrete four-box table failed to account for the mass variation within the MSM communities. Research on community subcultures has found that while men primarily identified with one particular subculture, there was also 'considerable overlap in many men's subcultural affiliations' (Prestage et al., 2015, 2231). For example, one could be a twink, a cub, a husband and a barebacker at the same time and adhere to different rules of conduct in different settings. Therefore, risk behaviour may have less to do with learned behaviours and more with negotiation techniques in the immediate risk situation. This was reflected in the shift in focus from factual information in MMI to individual negotiation in the 1990's, as outlined by Dodds (2002) above.

In response to the criticisms of these theories, Bloor (1995a) suggested a phenomenological alternative based upon Schutz's (1970) scheme of 'systems of relevances' (SOR), which acknowledged the role of unconsidered and habitual actions in risk management. Central to SOR was the combination of two modes of cognition: those based on routine on the one hand and on rational, calculative action on the other. The six stage process of interpretation and action developed in the scheme could be either elaborate or fleeting depending on the action's habitual nature and could account for changes in risk behaviours as a consequence of a shifting system of relevance. The first three stages were the relevances; topical, interpretative and motivational, which were considered before an interpretation of the situation was made. Topical relevances determined if the situation was considered dangerous by the individual, interpretative relevances were those to which the individual could compare to his current situation and motivational relevances represented the extent to which the individual was willing to pursue interpretative relevances. It was only at this stage that an interpretation of the situation was made and a decision was made about how to proceed. Bloor (1995a) found that the flexibility of this particular theory in overcoming the structural nature of the other theories was more suited to explaining the judgements made by his respondents when engaging in sex. It also pointed to the substantial complexities facing those who produced MMI who had to ensure that individuals reflected on behaviour that otherwise might have been considered fleetingly.

A more recent attempt in the field of health promotion theory has been a model that attempted to combine a variety of behavioural change interventions into one overall framework, called the Behavioural Change Wheel (BCW) (Michie et al., 2011). At the centre of this three-layered wheel was the COM-B model, which formed the hub of the wheel. The focus of the COM-B model was on three essential conditions (capability, opportunity and motivation - COM) that influenced

behaviour (B). Surrounding the COM-B model, there were nine intervention types that were used to address the three conditions of behaviour. These were further enclosed by the final circle of the wheel, which focused upon seven policy options that addressed each of the intervention types required.

Figure 3.1: The Behaviour Wheel (Michie et al., 2011)

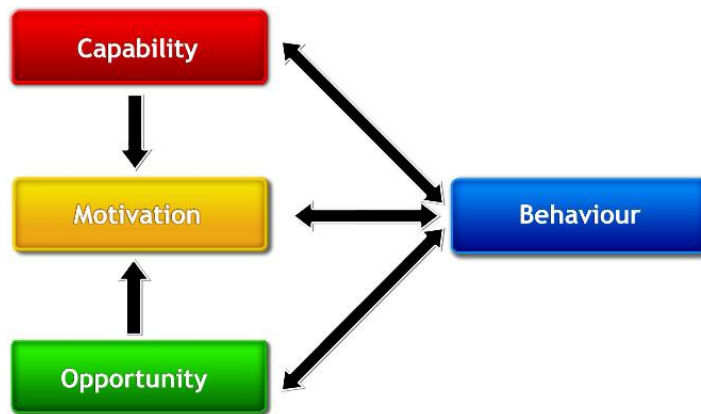


The COM-B system, therefore, was ‘intended as a starting point in order to choose interventions that are most likely to be effective, and specific interventions to address each component have been suggested’ (Jackson et al., 2014, 8). The policy categories could be then used to implement the required intervention.

However, the COM-B model could be further dissected, as the interaction between the three individual components of the model was not necessarily straightforward. While all three separate components could have influenced behaviour (and *visa versa*), capability and opportunity may also have influenced motivation. Therefore, if an individual was not capable

of carrying out a certain behaviour, this would have influenced their motivation, which subsequently affected behaviour. The same logic applied to opportunity.

Figure 3.2: The COM-B system – a framework for understanding behaviour (Michie et al., 2011)



However, these individual components that influenced behaviour were further subdivided into two categories each. Capability was divided between physical and psychological, opportunities were social or environmental and motivations were reflective or automatic. As a result, Alexander et al. (2014, 61, emphasis authors' own) stated that 'human behaviour results from the interaction between personal physical and psychological capabilities, to utilise social and environmental opportunities via motivators that are reflective (thinking with the head) or automatic (emotional 'thinking' with the heart)'. Therefore, the COM-B model not only allowed for the understanding of behaviour, but also the context in which it occurred (Atkins, 2016). Each of these components of the COM-B model was then linked with a specific intervention type/s, so physical capability was addressed by training and/or enablement, while automatic motivation was tackled by persuasion, incentivisation and/or coercion depending on the needs of the individual etc.

Although a relatively new framework for health promotion theory, the COM-B model and the BCW has been successfully adopted by both the Department of Health's tobacco control strategy

and NICE's guidelines on reducing obesity (Carney et al., 2016). Recent research has shown BCW's and COM-B's potential in a wide range of health fields, such as medication management (Sinnott et al., 2015), adult auditory rehabilitation (Barker et al., 2016) and the management of spinal cord injury (Berube et al., 2015). However, many of the authors pointed out that the COM-B model within the BCW was a relatively new framework and further research was needed to have a complete understanding of the framework's effectiveness and weaknesses. In the early stages of their research on designing digital-based interventions to increase condom use among young heterosexual men, Webster & Bailey (2013) found that gaining 'consensus between experts about which dimensions [of the BCW] were most important was sometimes difficult' suggesting challenges for the authors in dealing with key stakeholders when constructing their intervention. When these authors reported how they utilised the framework to create their website in a later paper, they also stated that the complexity of the system made some aspects of the BCW difficult to conceptualise (Webster et al., 2016). It was likely that these difficulties contributed to the time taken to construct interventions using the BCW. Sinnott et al. (2015) also found that the complexity of the BCW impacted upon the length of time taken from review to the refinement of the final interventions, in total three years, which they identified as one of the key weaknesses in utilising this framework. These criticisms of the BCW suggested that, while many authors acknowledged the benefits of the COM-B model and the BCW, issues related to the complexity of the framework and subsequent impacts this had on the time taken to construct meaningful interventions remained. However, given that this framework is relatively new in comparison to other theories, further research may yet reveal more benefits and challenges for the BCW.

The primary focus of this research will focus on what lessons can be learned from previous mass media HIV prevention interventions to address how MSM currently understand, evaluate and

respond to HIV risk *from their perspective*. Much of the literature on MMI has concentrated on analysis by various academics and researchers without considering the opinions of the MSM communities themselves. Therefore, this research will seek to address this gap in literature and give voice to the people whom these MMI seeks to represent.

Understanding Risk post-antiretrovirals

A central task of sexual health promoters is to ensure that their audience is aware of their risk of HIV infection. However, twenty years after the development of antiretrovirals, there has been dramatic increases in the number of MSM diagnosed with HIV. According to the most recent statistics, 'the number of men who have sex with men newly diagnosed with HIV continued to rise from 2,860 in 2010 to 3,360 men diagnosed HIV positive in 2014' (Skingsley et al., 2015b). While there has been some research suggesting that these increases were due to an increased uptake of HIV testing by MSM (Dougan et al., 2007), many others have questioned if the effectiveness of the antiretroviral drugs has caused MSM to re-evaluate their risk of HIV infection and their need to practise safer sex, which, in turn, has increased the practice of barebacking (Elford et al., 2000; Kelly et al., 1998). However, this belief in treatment optimism as a reason why men were increasingly engaging in bareback sex was not one supported by all the literature. Indeed, some studies have indicated no association between treatment optimism and sexual risk (Kalichman et al., 2007; Dukers et al., 2001), while another has pointed to an association between treatment optimism and reduced sexual risk (Nollen et al., 2002). Therefore, the exact nature of the relationship between treatment optimism and increased HIV risk was open to debate.

Suarez & Miller (2001) have also identified the *eroticisation of HIV* and *AIDS burnout* as primary factors that affected MSM's risk reassessment. Alongside the development of antiretrovirals, the image of seropositive men has changed from the skeletal to people who appeared healthy, physically fit and virile; thereby their image has become eroticised. This reinforced the notion that HIV is now a manageable disease which did not imply imminent death. AIDS burnout suggested that MSM have developed a fatigue with safer sex after thirty years of the condom code, due to a lack of newer, more meaningful intervention programmes (Suarez & Miller, 2001). Results from recent surveys have affirmed a trend towards barebacking, suggesting that MSM were reassessing their risk of HIV infection. The European MSM Internet Survey (2013) found that 56.6% of men in the United Kingdom reported bareback sex with a casual partner in the previous twelve months. A British report from the National Gay Men's Sex Survey (Hickson et al., 2010) also indicated that less than one third of respondents had always used condoms for anal sex in the previous year.

Risk became an important term in sociology when Beck (1992) first coined the term to link the emergence of new risks with the specifics of modernity. Beck (1992) employed the notion of the 'risk society' - a society faced with the unintended, negative consequences of economic development in the industrial age, such as ecological and nuclear threats. The growth of the 'risk society' was a deliberate result of the un-reflexive nature of scientists, technicians, etc. who did not foresee the consequences of their actions (Beck, 1992). Many of these actions occurred prior to our birth making life an endless struggle with social forces that are beyond our knowledge and control. As Beck (1992, 22) pointed out:

"They [risks] induce systematic and often irreversible harm, generally remain invisible, are based on casual interpretations, and thus initially only exist in terms of the (scientific or anti-scientific) knowledge about them."

However, Beck presumed that we have all equal access to flows of information concerning risks. In doing so, he failed to recognise that there was enormous inequalities in the distribution of material and figurative resources (Coulter, 1999). Our knowledge of risks may not have come directly from experts; rather it may have come through several filtering stages, which may have contributed to the observed differences between actual and perceived HIV risk behaviours noted by Kesler et al. (2016). There were certain agencies, institutions and individuals with power within a society who were capable of obscuring or concealing certain information which they chose not to be not in their interest (Coulter, 1999). As a result, these agencies promoted information that was in their interest, but not necessarily in the interest of others. Consequently, we became reliant upon those with power for disseminating balanced information from experts (Coulter, 1999). This gave these agencies enormous control in advising the public on matters of their interest. Within the MSM communities, access to the MSM media tended to be more limited as it was confined to free literature available primarily on the gay scene. However, online sexual health promotion became increasingly common in the MSM communities in the new millennium, providing new opportunities to reach men who do not attend the commercial gay scene (Bolding et al., 2004). Nevertheless, the balance between risk and risk consciousness, which Beck took for granted, may not be as straightforward as previously thought.

In describing late-modernity as a risk culture, Giddens (1991) differentiated between the *end-of-tradition*, which he associated with modernity, and the *end-of-nature*, which dominated late-modernity alongside the *end-of-tradition*. The *end-of-tradition* signified that life was no lived as fate. For example, new knowledge that stemmed from the development of the sciences and technologies meant natural disasters (e.g. earthquakes), could be understood as having a root cause (shifting tectonic plates), rather than a result of fate (God's will). As a result, the risk of

natural disasters were understood as something over which humans potentially exerted some control. Risks were no longer seen as external, but manufactured by humans. With this new knowledge, came the *end-of-nature*, in which people began to realise that there were very few aspects of the world that were untouched by human intervention:

‘At a certain point, somewhere in the last fifty years or so, we stopped worrying so much about what nature could do to us, and we started worrying much more about what we have done to nature. That transition makes one major of entry into risk society. It is a society which lives after nature.’

(Giddens, 1998, 26)

Therefore, risks became omnipresent in Giddens’ understanding of the risk society and avoidance of such risks became increasingly difficult.

One of the primary differences between Beck’s and Giddens’ analysis of risk was Giddens’ focus on trust (Lupton, 2013). Within late modernity, social relations were lifted out of their social context and placed in the hands of ‘expert systems’, which Giddens (1991, 27) described as ‘systems of technical accomplishment or professional expertise that organise large areas of the material and social environments in which we live today’. The trust that was once tied up in kinship relations or local communities was severed, as late-modern society progressed (Giddens, 1991). The development of industrial society and its impersonal nature, forced people to place trust in the technical competencies of other people they may have never met or known. However, within late-modernity, trust was in constant battle with a greater knowledge of a rising number of risks, which in turn led to an increasing reassessment of risk (Giddens, 1991). Taking the example of the AIDS crisis in the early eighties, Giddens (1998) also highlighted the balance that needed to be maintained between providing information to the public about risk and scaremongering. If governments and experts highlighted the risk associated with unsafe sex to

persuade people to change their sexual behaviours, and the AIDS crisis did not materialise in the way the public expected, there was likely to have been a negative response from the public to the message. Therefore, governments and experts needed to present balanced information to the public without scaremongering to maximise the possibility of the public reassessing risk.

The increased uptake of various forms of media has meant that the public has more access to differing expert opinions than ever before, which has led to a society dominated by the 'politics of anxiety' (Turner, 1991, 24). We have realised that no expert system is as expert as we once thought, and that our trust in them requires constant scrutiny and monitoring. However, this does not necessarily mean that all lay experts necessarily rejected the opinions of expert systems, as the interpretation of messages depended on a wide range of factors, such as their cultural capital, knowledge and/or personal experience (Anderson, 2006). Indeed, many embraced the knowledge of experts and actively sought preventative interventions, particularly where their health was concerned. As Lupton (2006, 17) pointed out:

'Being categorised as 'at risk' from a medical problem means that one is placed in a liminal category of wellness: neither actually ill (yet) nor fully well. Such people may feel the need for constant reassurance that nothing is wrong, and indeed often actively seek out medical testing or other interventions to protect themselves from the imputed risk and gain some measurement of certainty about what the future may hold.'

Therefore, just as Coulter (1999) criticised Beck's theory on the basis of access to material and figurative resources in relation to accessing flows of information above, a similar criticism has been levelled at Giddens' by Anderson (2006) who questions the interpretation of such messages. In addition, Lupton's (2006) assertions about the concern that some people had about their health in the light of various risks also seems to point to an acceptance of expert

knowledge in late modernity. Consequently, it could be argued that the politics of anxiety (Turner, 1991) may not have had as much influence on expert systems as previously assumed.

In her anthropological analysis of risk, Mary Douglas (1985) placed culture at the centre of her analysis of risk understanding. She differentiated between expert and lay understandings of risk, in which the latter were incorporated with other cultural concerns, which affected lay people's understandings of what constituted a risk. From this perspective, understandings of risk were not individualised, but embedded within the cultural context to which the individual belonged. Therefore, understandings of risk were communal rather than individualistic. However, cultural understandings of risk were also inevitably bound up in the moral and political opinions of the specific culture. During this binding, blame was usually attributed to a section of those outside the primary culture. In such a context, some risks were overestimated, while others were underestimated, depending on the moral and political dimension of the risk. One of the consequences of this process was to place blame for the risk on an 'other'. As Lupton (2013 172) points out, 'in most cases, notions of Otherness – and the consequent stigmatising and marginalising of the Other – remain central to ways of thinking and acting about risk'. The conception of the other and its use to assign differences, imagined or otherwise, onto minorities has been used to justify racism, homophobia, xenophobia, misogyny etc. (Sibley, 1995). However, the separation of the self from the other also separated the risk associated with the other from the self. In doing so, the majority culture believed it could protect itself against risk by focussing on the other, whether or not the majority are also at risk. However, while Douglas has been praised for bringing her analysis of risk beyond the individualistic approach of other theorists, her functionalist structural analysis of risk has been criticised by many authors who see the limitations of her work. As Lupton (2013, 57) highlights:

‘Her [Douglas’] approach does tend to be somewhat static, however, as is typical of functional structuralist analyses of sociocultural phenomenon. There is little explanation provided for how things might change in Douglas’ accounts of risk purity and danger’

Nevertheless, Douglas’ analysis of risk perception has been incorporated into some psychological analysis of risk to which I now turn.

The most notable influence that Douglas has had on the psychology of risk has been in relation to the social representations approach. Challenging how risk was perceived in the optimistic ‘bias’ approach, which stressed the importance that emotions (Oatley, 1996) and worldviews (Slovic, 1997) have on risk understanding, Joffe (1999) sought to place social representations at the heart of risk understanding. Although most of the information about risk came from the media, how we reacted to them was based on our experiences of past risk. Therefore, our understanding of new risk was effected by our previous experiences of risk. However, how we reacted also stemmed from what psychologists describe as ‘splitting’, which was developed within the psyche from the anxiety an infant experiences during childbirth. Joffe (2003, 62) describes this process as an:

‘unconscious defence mechanism [that] is generally associated with taking into the self good experiences and feelings, and projecting outward bad experiences and feelings. The goal of splitting, manifest in representations, is to keep the bad away from the good in the hope that the good will not be invaded and destroyed.’

Taking this experience of splitting, Joffe (2003) implied that people experienced risk, and hence the source of danger, by associating it with others outside their own group. Therefore, risk became associated with strategies of exclusion and avoidance (Wilkinson, 2006). Taking Joffe’s example of AIDS, Wilkinson (2006, 33) explained that:

‘Social representations of the risk of contracting AIDS function both to shore up a group’s sense of solidarity and self-righteousness as well as a means to portray this as a problem for the ‘others’ who are not like ‘us’; differences in the ‘risk perception’ are much more a reflection of a group’s defensive reactions against anxiety than a product of mental heuristics in the estimation of statistical probability.’

Embedded in the social representations approach, therefore, was a rejection of the notion that individuals were driven by a rational process of decision-making. The process of splitting affected how we understood anxiety and processed information about risk. In doing so, the individual sought to blame others who they believed were outside their own group. This process of exclusion meant that they could appropriately deal with the risk by placing it onto the *others*.

Although Foucault did not write extensively about risk himself, his theories have been applied to the concept of risk, most notably in relation to health. A central theme of Foucault’s work was governmentality, which involved the move from sovereign power, which dominated traditional societies, to disciplinary power, which was managed through a system of surveillance. Disciplinary power was the result of the collection of data in modern societies and was defined as ‘the way in which bodies are regulated, trained, maintained and understood, and is most evident in social institutions such as schools, prisons and hospitals’ (Nettleton, 2006, 117). The collated data was used to calculate risk by creating a normalised standard of judgement (the healthy body) against which others were measured. Those who did not meet such measures were deemed ill, or potentially ill, and hence were regulated through a risk discourse. Disease was no longer solely understood in the context of events happening inside of the body, but understood in terms of the individual’s relationship with their social world

(Annandale, 2007). In relation to HIV, MSM were considered to be 'at high risk' of infection because of their lifestyle and 'a method of surveillance and the control of specific behaviours [was needed] to regulate a 'dangerous' form of sexuality' (Saunders, 2006, 98).

Much of the discussion of sexual risk management in more recent MMI has focussed on the individualisation of risk. Risk has become understood in terms of human responsibility rather than outcomes of fate. The individual was encouraged to be a good citizen and take responsibility for his/her own health. Utilising Foucault's notion of governmentality in relation to risk and HIV, Holmes et al. (2008) suggested that:

"Notions of governmentality and risk focus on the subject's position with the discursive construction of risk, most specifically the manner in which individuals should be personally responsible for their well-being, and with this increased focus on individual responsibility, risk assessment has become a major industry."

(Holmes et al., 2008, 173)

Experts in the field of HIV could define risk, but could not reduce or remove it, so self-surveillance and individual responsibility was encouraged. This focus away from the disease and onto personal behaviour has drawn attention to lifestyle in the discussion of prevention (Blaxter, 1990). HIV became another risk for individuals to manage and it was left to the individual to make a risk assessment about their partner. This has given rise to seroguessing when an open discussion about serostatus was not held. Even with discussion, partners may have been unaware of their own serostatus, may have wished to withhold this information, may have lied, or may have been misunderstood by their partner. Ironically, discussions like these may have placed an individual at a greater risk of infection as a result. Power, according to Foucault (1980), was inherent in all relationships, even between two men. What was to one man's benefit (the pleasure of unprotected anal sex) may have been to the other's detriment (increased HIV risk).

Therefore, the contestation that individuals can ever take full responsibility for their own sexual health, as suggested within the individualisation of risk, is open to debate.

There is now considerable evidence to suggest that MSM are putting themselves at greater risk of HIV infection than before. Considering this information, this research seeks to explore how MSM understand and conceptualise their risk of HIV infection post-antiretrovirals and if this has changed over time.

Masculinities and Risk

There are a wide range of social, cultural and psychological factors that inform HIV risk perception in both the heterosexual and MSM communities. Much literature has been given over to a variety of influences on HIV risk perception and the effect this had on decisions about the HIV risk. However, many of these studies found that respondents of all sexualities often 'rated their self-perceived HIV risk as low despite high risk behaviours' (Pringle et al., 2013, 580). Therefore, people often underestimated their own HIV risk to others while they used similar techniques to comprehend risk from others.

When people were left to make decisions on their own about who was a risk to them, it was quite usual for them to resort to stereotypes. Research has shown that people who looked like they were promiscuous were often deemed to be so, while others were seen as safe (Skidmore & Hayter, 2000). Much of this research pointed to the fact that many people made risk judgements based upon their own standards. If the potential partner was deemed to be 'like me', then they were seen as not to pose a sexual risk. As Skidmore & Hayter (2000, 24) stated

‘with regards to sexual encounters, if one perceives a partner to be like oneself then one’s personal attributes are invested in that person and this lack of objective judgement could fail to identify health risks’. Certain attributes, such as social class, appearance, social demeanour, length of relationship and if the potential partner was deemed to be like ‘me’ influenced risk perception (Skidmore & Hayter, 2000). Similar research carried out on young gay black men has also shown that decisions about HIV risk were made in a comparable fashion (Fields et al., 2012). However, in addition to appearance, these men associated reduced HIV risk with ‘not being openly gay, lacking any feminine characteristics or tendencies, being strong or aggressive, or being the insertive partner in anal intercourse’ (Fields et al., 2012, 299). These men, particularly those who were married, were thought to have limited exposure to the gay scene and hence to seropositive partners. However, decisions about HIV risk have also been found to be based on other factors such as love, intimacy, trust and lust causing ‘a discrepancy between a perception of risk and risk of actual behaviour’ (Goldenberg et al., 2015, 618). These emotions were reported with both casual and regular partners and influenced the risk decisions made by men. This suggests that, while men made risk assessments, emotions have also affected their decisions about whether or not to use condoms during sex. Therefore, decisions about risk perception were complex and may have been influenced by previously established understandings about HIV risk and other factors, such as emotions.

One of the main factors that informed HIV risk perception was drug-related behaviour, particularly when drugs were injected (MacKellar et al., 2007). In the MSM communities, the use of crystal meth by partners was deemed to impact on HIV risk perception and those who used this drug were considered to have previously engaged in higher risk behaviours (Nanin & Parsons, 2006). In a similar way, those who consumed high amounts of alcohol were deemed less likely to have used condoms with previous partners (McNair et al., 1998). Psychologists, on

the other hand, have proposed a wide range of factors that influenced HIV risk perception, including internalised homophobia, low self-esteem and post-traumatic stress disorder (Halperin, 2007). Either way, Stephenson et al. (2015, 1817, emphasis authors' own) found that 'participants reported higher perceived prevalence of HIV for groups that were further away from themselves...suggesting a sense of 'othering', that is, the perception that HIV is a risk for others, but not as much of a risk for themselves'.

While each of these factors were worthy of investigation in themselves, I have chosen to focus on the impact of masculinities on HIV risk perception. Connell's (1995) notion of hegemonic masculinity excluded MSM on the basis that they violated heterosexuality. Nevertheless, while being excluded from hegemonic masculinity, MSM still conformed to masculine scripts with their sexuality being constructed 'in the context of socially and culturally produced masculinity expectations' (Mutchler, 2000, 17). Thus, some MSM may have felt gender role strain and enacted a form of hypermasculinity to compensate for their exclusion from hegemonic masculinity (Eguchi, 2009). This embodiment of hypermasculinity impacted upon men's health, with research 'consistently drawing a link between a pattern of men's poor health behaviours, adoption of high health-risk activities and a reluctance to seek general health and medical advice with hegemonic constructs of masculinities' (Lohan, 2010, 14). Research on heterosexuals has established links between masculinities and HIV risk, particularly the reluctance to be tested for HIV and having multiple partners and/or high-risk sex (Dworkin et al., 2009, Dworkin 2015, Higgins et al., 2010). Other research has found that masculinities influenced choices about condom use (Shernoff, 2006b), drug use (Halkitis, 2000), sexual positioning (Grov et al., 2010) and number of sexual partners (Parent et al., 2012). Other authors have investigated the links between masculinities and men's reluctance to discuss their health (Courtenay 2000). Shoveller et al. (2010, 67) stated that men's 'pronounced silence' about sexual health needs should be

addressed in public health promotion programmes. In addition, Knight et al. (2012, 1248) stated that 'sexually active men who avoid discussing sexual health have an increased risk of contracting an STI compared to those who discuss sexual health'. Therefore, it was imperative to understand how masculinities affected the lives of MSM in this research to understand how it may have influenced their HIV risk perceptions. This was particularly important given that the high numbers of late HIV diagnosis (Skingsley et al., 2015a) may have indicated a reluctance of men to engage with sexual health services.

The discourses of risk discussed in the previous section were framed within the context of danger and hazard, but Zeglin (2015) has noted that masculinities played an integral role in the spread of HIV in the MSM communities. Research on boys showed differences in how they viewed risk in comparison to their female counterparts suggesting that masculinities influenced risk perception from a young age. Boys were more willing to engage in risky behaviours and less concerned with others gaining them 'masculine capital' (Green, 1997 cited in Holmes et al., 2008, 174). However, a number of counter-discourses in society run parallel to the traditional view of risk, in which risk is understood to be more positive and exciting. Within the 'discourse of emotional engagement', people took risks:

"to seek a heightened degree of emotional intensity that is pleasurable in its ability to take us out of the here-and-now, the mundane, everyday nature of life...There is a sense of heightened living, of being closer to nature than culture, of breaking the 'rules' that we see society as imposing on us."

(Lupton & Tulloch, 2002, 119-121)

From this perspective, risk became attractive as it was exciting, pleasurable and helped men to escape the norm of their lives. It was a way in which MSM could transgress the governmentality that 'society imposes on us'. Many men in their discussions of bareback sex spoke of the

excitement of transgression, of breaking rules, adventure etc. in the context of masculinities (Ridge, 2004). A respondent to Ridge's research (2004) explained the excitement of breaking rules in the context of bareback sex:

'...any physical relationship with any person, is very bounded and very careful and very safe and very...you are never being dangerous or radical. And that was quite a sexual thrill to do something dangerous. It was going beyond the boundaries, that is what sex is all about...about breaking the taboos. It [barebacking] was an incredible thrill'

(Ridge, 2004, 266)

It was evident that many of the 'taboos' which this respondent discussed are the current safer sex discourses, which have tended to dominate the lives of many MSM (Baker, 2005). When the discourse of emotional engagement competed with the traditional view of risk, conflict was bound to arise (Lupton & Tulloch, 2002). From this perspective, barebackers may have seen this positive view of risk outweighing the negative.

When such a conflict arises, it was up to the individual to decide about the risk they were about to take. However, in Foucauldian analysis, regulation of the population came not only from external surveillance, but how that surveillance was accepted by individuals to the extent that they engaged in self-surveillance themselves (Vaz & Bruno, 2003). Therefore, it can be suggested that many MSM have engaged in surveillance of their own sexual activities since the beginning of the AIDS crisis. However, when the imperatives of safer sex came in conflict with individuals' desires, a sense of dissonance occurred (Holmes and Warner, 2005). The emergence of the bareback subculture suggested that more people were willing to transgress these rules to be 'real' men. Robertson and Williams (2010, 55) stated that 'these normative discourses about

what constitutes a '*good citizen*', in terms of healthy lifestyle '*behaviours*', can clash with the social practices required within hegemonic masculine discourses'. Historically, because heterosexuality has been defined as the 'norm' against which other forms of sexuality have been measured, MSM have been known for their sexual transgressions (Beasley, 2010). The advent of AIDS in the early-1980s forced MSM to abandon this tradition for the sake of their survival (Feldman, 2010). However, the increasing number of new HIV diagnosis (Skingsley et al., 2015b) suggests that many MSM seem willing to transgress the rules and engage in barebacking. The research discussed above suggested that masculinities play some role in this transgression.

Some men who have strived to reach the ideals of hegemonic masculinity have embraced risk to climb the hierarchy of masculinity (Linneman, 2000). At the top of this hierarchy was the aspirational hegemonic masculinity, which Connell (2005) defined as:

"the configuration of the gender practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women."

(Connell, 2005, 77)

According to Connell (2005), hegemonic masculinity was the socially dominant form of masculinity in any given historical period or society and was therefore historically mobile and flexible. Connell (2005) emphasised the impact of social issues such as class and race on masculinities, which gave rise to various forms of *masculinities*, rather than a singular form. Frequently constructed in relation to women and subordinated men, hegemonic masculinity was primarily maintained through media content, religious doctrine, wage structures, welfare policies etc. (Connell & Messerschmidt, 2002). According to Connell (2005), qualities associated with hegemonic masculinity include exclusive heterosexuality, virility, risk-taking, bravado, authority, physical strength, and independence. It was through the term 'hegemonic

masculinity' that it was possible to understand the multi-dimensional and socially constructed aspects of male dominance in modern society.

MSM historians have identified a shift in identification away from the effeminate MSM to a more masculine one since the early 1970's (Humphreys, 1971, *cited in* Nardi, 2000). Within a few years of Humphreys' work, the hypermasculine clones were embodied in the pop group, The Village People, and their hit 'Macho Man' (1979) embedded this notion in popular culture. Many MSM sought the body and appearance that was attributed to the prowess of the heterosexual male and sought to distance themselves from feminised MSM, most notably when their own masculinity was called into question (Hunt et al., 2016). Halkitis (2000) stated that the onset of AIDS in the early 1980's accelerated this process as 'the desire to achieve the masculine ideal, which was a psychological and social reaction for decades for gay men before AIDS, became an essential need to strengthen one's body potentially ravaged by AIDS' (Halkitis, 2000, 133). In the face of an unidentified disease, many MSM, both seronegative and seropositive, joined gyms to build body strength should they have needed it in the face of the disease. Bodybuilding continues to be used by seropositive men to minimise the effect of lipodystrophy on their bodies caused by antiretroviral drugs (Halkitis et. al. 2004). Therefore, the new masculinised image of MSM predominated, which has led to a division between masculinized and feminized MSM (Glick et al. 2007). However, while this division seemed relatively straightforward, many MSM reject both hypermasculinity and effeminacy, embracing what Connell (2005) referred to as a 'very straight gay', where MSM enacted both hegemonic and gay masculinities in their daily lives. While subverting the hegemony of heterosexual masculinities, these men were also complicit in upholding notions of hegemony, the very system that subordinated them in the first place (Connell, 2005). This made the relationship between MSM and hegemonic masculinity a complex one and their point of intersection unclear.

The effect of masculinities on men's health has been the subject of much discussion among health sociologists. Statistics have consistently indicated that men died younger than women, although this 'female advantage' in health has been widely challenged (Barry & Yuill, 2008; Wainright, 2008; White 2010). While Sloan et al. (2015) have found that some aspects of masculinities were associated with health promoting behaviours, other research has suggested that, as men moved towards traditional masculine ideals, they also adopted practices that put their health at risk (Mahalik et al., 2007). In particular, risk-taking activities such as partaking in dangerous sports, excessive drinking and driving irresponsibly have contributed to men's early death. The Annual Report from the Regional Director of Public Health in 1994 stated:

'The fit healthy male who avoids a heart attack is also likely to be the person who plays dangerous sports and drives too fast and who would probably find his macho image somewhat dented by seeking counselling or support if things were not going too well.'

(WMRHA, cited in Annandale, 2007, 139)

However, risk-taking cannot be understood as taking place within a vacuum. Risks often compete with one another and the neo-liberalist effect on health promotion has left it to the individual to decide where the balance lies. As Carter (1993, 158) points out, 'discourse of masculinity often classify risks into two dimensions; the taking of some and avoiding others. Masculine identity becomes a complex negotiation between two risk dimensions' (cited in Robertson, 2007, 158). So one set of risks may be taken to offset another. For example, when discussing the low take-up of PrEP, Dean (2015, 229) discussed the competing risks between acknowledging a desire for bareback sex and the risk of being identified as an irresponsible actor:

'For gay men to identify themselves as 'at risk' entails their acknowledging a desire for raw [bareback] sex that goes against community norms. To acknowledge this

desire is potentially a risk in itself, because it compromises our (sic) image of the responsible gay man who always practices safer sex.'

Therefore, risks were not always isolated and often interacted with one another. Decisions about where the greatest risk lies were often left to the individual to decide.

MSM no longer talk of 'sex without condoms' and barebacking, a term which is highly gendered, has now been firmly embedded in queer vernacular. The term drew heavily on the quintessential all-American cowboy hero who took risks by riding his horse at the rodeo without the safety and security of a saddle. This allusion to an embodied form of a hegemonic masculinity whose prowess was based upon his risk-taking had significance for how barebacking was perceived by MSM. However, it was not only the definition of barebacking that was masculinised; the action of engaging in bareback sex was also masculinised (Thomas et al., 2014). While there is much established literature on the linkages between safer sex and HIV prevention, Dean (2009, 52) suggested that the act of using a condom comprised a barebacker's masculinity:

'Rather than offering protection, condoms make a man and his masculinity vulnerable to doubt and derision. Latex comprises not only sensation and intimacy but also masculine identity. From this perspective, HIV becomes simply another trial, the endurance of which proves one's mettle.'

The condom became understood as a threat to masculinity, while 'real' men took risks. This was seen as being particularly important for the masculinity of the receptive partners. According to Dean (2009), receptive barebackers re-established their masculinity by proving that they were the one who took the greater risk of HIV infection and were prepared to take the consequences of their actions. Another of Ridge's (2004) respondents explained how he felt about being a

receptive bareback partner and how he felt he had received the active partner's masculinity into him:

'And it's like...it's almost like this man is injecting some of his masculinity into me...giving me some of that. And so I find it [receptive anal sex] a very augmenting experience as opposed to a diminished experience...In a sense, it's sort of like me taking something from him'.

(Ridge, 2004, 266)

Interpreting the discussion above, we could say that while in the receptive position, this respondent became hyper-masculinised, as he was not living by the rules, but *actively* taking risks with HIV infection. When he eventually overcame his fear of HIV infection, the barebacker took control of his own destiny and, as a result, his masculinity.

While many authors have questioned the existence of 'bug-chasers' beyond an online fantasy (Grov & Parsons, 2006), or qualified their numbers as insignificant (Tewksbury, 2003), others have suggested that 'questioning the scope and nature of bug chasers' existence may encourage some readers to devalue the group's overall contribution to public health discussion' (Malkowski, 2014, 221). Nevertheless, taking their existence as given, Dean (2009) suggested that notions of masculinities, risk and unsafe sex can be extended to 'bug-chasers'. By refusing to take HIV tests, 'bug-chasers' could continually have unprotected sex imagining that each occasion was the one which transmitted the virus. In doing so, 'risk can be perpetually renewed, and one's masculine capacity for tolerating risk ever more enhanced... [the bug-chaser] may collect other men's bugs inside his body and become some sort of terrarium' (Dean, 2009, 53). The excitement for the 'bug-chaser' was in taking risks and in doing so, he became hyper-masculinised on every occasion he had sex. According to Dean (2009), the 'bug-chaser' was the ultimate risk-taker. Knowing his serostatus would have meant he no longer took the same risks

and therefore many 'bug-chasers' have refused to take HIV tests (Dean 2009). Thus, the more sex the 'bug-chaser' had, the masculine he felt/became.

Many men, both hetero- and homo-sexual, have seen semen exchange as an essential element of the sexual experience. In her study of the meanings of semen for men, Moore (2007) pointed out that one of the reasons that heterosexual men were in crisis¹⁶ was because their semen, which she termed as a 'stand-in for men' (Moore, 2007, 112), can now be manipulated by the reproductive sciences. She found that this loss of control over the reproductive process left men powerless and had a destructive effect on their masculinities. However, while this may have been the consequences for heterosexual men, the association between DNA and semen allowed some MSM to equate semen exchange with that of heterosexual sex, thereby adding a transformative element to sex (Grundy-Bowers et al., 2015). A respondent to Ridge (2004) cited earlier, spoke about semen exchange in the context of having masculinity injected into him. Similar discourses arose when MSM spoke about the effect condom use has on semen exchange (Holmes & Warner, 2005). A bareback blogger, Geek Slut (cited in Dean, 2009, 54) discussed the 'naturalness' of semen exchange as part of gay sex, something which he felt was nullified by the advent of AIDS and the use of condoms:

'The need for seed [semen]. Once a natural part of queer culture has become a sleazy kink. We glorify it. We enjoy it. I guess it's payback, you know. After spending years, our cocks wrapped in plastic marching to the 'Safe Sex' rhythm. That didn't work. It was doomed from the start. We're human beings. Men. We're not above nature. We ARE nature.'

¹⁶ Much of literature on masculinities debate whether or not men are in crisis. See Edwards (2006) for a full debate.

Similar research examined the importance of semen exchange as part of the sexual act for MSM and suggested that there was an intimacy that cannot be gained from having safer sex (Schilder et al., 2008). Indeed, semen was eroticised in such a way that it transformed from a high-risk fluid into something that was desirable for MSM barebackers, even when other factors such as serostatus of partner were considered (Klein, 2016). This indicated that while the contexts between MSM and heterosexual men were different, the desire for control over their semen, that being a definer of masculinity, remained the same. While semen exchange increased the risk of HIV acquisition, sexual health workers were aware of the importance of semen for some MSM and the difficulties this caused for the onward transmission of HIV (Hickson, 2011).

Masculinities have also shown to play a key role in the type of relationship agreements made by MSM couples. Wheldon & Pathak (2010) examined four different types of relationships (monogamous, open with no anal, open with safe anal and open with unsafe anal) and the effect that normative masculinity had on each of these. The authors used a definition of normative masculinity that emphasised 'sexual conquest, emotional detachment, the pursuit of sexual gratification for its own sake, and the association of danger and excitement in sexual encounters' (Wheldon & Pathak, 2010, 467). Their findings showed a correlation between men with a high endorsement of normative masculinity and open relationships without restrictions on condom use in extra-dyadic encounters. By influencing the type of relationship negotiated, the authors indirectly linked normative masculinity with increased risk of HIV and STI infection. Equally, however, these men may also have engaged in risk-reduction practices, such as serosorting and strategic positioning, which indicated an awareness and attempt to minimise the risks they were taking (Wheldon & Pathak, 2010). While suggesting that attempts to change attitudes towards normative masculinity may have increased safer sex agreements, the authors also questioned if MSM's assimilation into heterosexual institutions, such as marriage and adoption, would

increase heterosexual norms, such as monogamy, within the MSM communities. Given that the advent of AIDS did not significantly reduce the numbers of gay men engaging in open relationships for sexual health reasons (Davidovich et al., cited in Bonello, 2009), it may be that Wheldon & Pathak were somewhat optimistic in their predictions.

This research seeks to examine the role masculinities play in the sexual experiences of MSM and how this affects their understanding of risk. As this review indicated, much of the research in this area suggested that the pressures of masculinities came into conflict with traditional understanding of risk as something that was dangerous. However, this focus on one particular type of MSM masculinity, as the transgressor, concealed many other forms of MSM masculinities. This research seeks to explore how and if other MSM masculinities contain similar counter-discourses of risk and examine this in the context of HIV.

Relationships, Risk and Negotiation

There are many different forms of relationships that lie outside the heteronormative ideal of monogamy in both the MSM and other communities. Much of the literature in the field of non-monogamies has focussed upon polyamory, which are relationships involving multiple partners that are both physically and emotionally close in nature (Frank & DeLamater, 2009). The emotional connection in polyamorous relationships are what makes them stand apart from swinging and MSM open relationships, which are generally sexual in nature and may involve one or both of the primary couple partners (Frank & DeLamater, 2009). While it cannot be denied that some MSM relationships may be polyamorous, the majority of open relationships have tended to be more sexual in nature. While the exact percentages varied between surveys, a

study of British gay men found that 56.3% of gay men in relationships described them as 'open' (Hickson et al., 1994, 198). Research has suggested that, while open relationships between MSM couples can be as emotionally healthy, they often had lower levels of commitment than monogamous relationships (Whitton et al., 2015). However, if a man was jealous of his partner, then they were less likely to be satisfied in an open relationship than in other relationship types (Hosking, 2014).

What MSM understood as 'open' and 'monogamous' has been shown to differ between individuals and Parsons et al. (2013) have suggested that using such a dichotomy may fail to encompass the wide variety of relationship structures within the MSM communities. Shernoff (2006a, 411) found enormous variation in what couples defined as monogamy with some considering 'cyber-sex or even masturbating to pornography a violation of a monogamous agreement...[while] other couples permit three-ways, and this is not viewed as a breach of monogamy'. Other research has found that MSM couples who have agreed to an open relationship never have acted upon it, while those within 'monogamous' relationships often had sexual partners other than their primary partner (Blasband & Peplau, 1985). Consequently, the exact extent and nature of non-monogamous relationships in the MSM communities has been difficult to gauge.

While much of the literature on MSM relationships discussed non-monogamies, little attention has been paid to how MSM view monogamy. Duncan et al. (2015b) found that many monogamous relationship agreements between MSM were often implicit in nature, relying on feelings of trust and stability rather than formalised agreements. In Adam's research (2006, 13), gay men were said to view monogamy from three perspectives: 'as an ideal to which practice should aspire, as an uncomfortable pretence, or an unnecessary constraint'. While respondents

presented monogamy as an ideal, they also acknowledged that they, their partner, or both would have difficulty living up to this ideal, so it became seen as a constraint against what was felt were 'natural' male urges, or a pretence in which one or both men lied about extra-dyadic sex. When extra-dyadic sex did happen in 'monogamous' relationships, it was often dealt with by silence. This had consequences for the spread of STIs and HIV within such relationships. It was also one of the reasons given by men in support of open relationships where agreements can be made for such circumstances to be managed:

'Monogamy...has simplicity on its side and it purports to defend the couple from outside threats, but at the same time, many men chafe at its limitations, and the potential gap between words and deeds poses other dangers in the form of HIV infection.'

(Adam, 2006, 15)

The honesty contained within open relationships was seen as favourable to monogamous relationships where one or both partners lied about extra-dyadic sex. Commenting on a magazine article which followed two seronegative couples, one monogamous and one open, where the couple in the 'monogamous' relationship subsequently became seropositive, a respondent to Adam's interviews acknowledged that 'I think the best condoms, like the best relationships, occasionally leak' (Adam, 2006, 15). Acknowledging this 'leak' within the context of openness was understood as a way to protect a couple against HIV infection rather than within the pretence of monogamy. Research has shown that agreements made about extra-dyadic sex in the context of open relationships were generally kept and were seen as more honest than monogamous relationships (Prestage et al., 2008). While it was generally felt by sexual health promoters that monogamous relationships helped reduce HIV/STI transmission (Baggaley et al., 2010), from these perspectives it was presented as a greater danger than open relationships. However, Mitchell (2014) found that almost a third of those who had an open

relationship agreement with their primary partner had broken an element of that agreement, mainly by engaging in bareback sex with a casual partner, something they did not inform their primary partner about. Therefore, while open relationships were generally thought to be more honest, in these cases, a significant number of men were placing their partner at risk of HIV/STI infection by breaking an element of their agreement.

How people negotiated non-monogamies has been a source of interest for researchers. What was evident from these discussions was that each couple made their own arrangements and there was no one clear ideal to embrace (Hoff & Beougher, 2010). However, a process known as compartmentalisation, 'the cognitive process of separating sex from emotions' (Bonello, 2009, 123) was seen as essential for the maintenance of the emotionally exclusive dyadic relationship. Some couples made specific arrangements to maintain compartmentalisation and to minimise jealousy, such as agreements never to see the same person twice, not sleeping over, keeping certain sexual acts/negotiated safety exclusive to the primary couple, not having sex in the couple's home and/or not maintaining contact with the other person afterwards (Bonello, 2009). Others kept a 'threeway or no way' arrangement to ensure that compartmentalisation was monitored and maintained (Bonello, 2009). Breaking such agreements was often tantamount to the deceit of having an affair without the other's knowledge. However, as Barker and Langdridge (2010, 761) pointed out:

'the kinds of boundary negotiations described...are happening within monogamous, as well as explicitly non-monogamous relationships. It seems that people in relationships are generally concerned with where lines are drawn on continua of sexual and emotional exclusivity'.

Discussions around the use of pornography and fantasies were equally commonplace within some monogamous relationships (Barker & Langdridge, 2010), so these types of negotiations

were not solely exclusive to non-monogamous couples, but rather a development of discussions that all couples had.

The influence of masculinities on non-monogamous agreements has been examined within the area of gender studies. Compartmentalisation itself was highly associated with traditional masculinities (Shillington, 2013). According to Bonello & Cross (2010, 120, emphasis authors' own) in their discussion of compartmentalisation, 'men, both gay and straight, "in contrast to women", are able to cognitively separate sex from emotions (or love)...something traditional masculine men are socialised to do'. The suggestion was that the more one associated with the notions of hegemonic masculinity, the easier it was to compartmentalise and consequently to engage in extra-dyadic sex. However, while some men could fulfil fantasies and engage with multiple partners proving their sexual prowess and hence aspects of their masculinities, they also had to surrender the *territorial possession* of their primary partner to other men (Sheff, 2010). Therefore, while hegemonic masculinity encouraged men to have multiple sexual partners, open and polyamorous relationships also undermined their position as the alpha male in control of their primary partner. Speaking of men in straight polyamorous relationships, Sheff (2010, 635) stated that 'hegemonic masculinity allows, and even encourages, men to have multiple (female) sexual partners, but sharing those women with other men undermines the celebrated alpha male position'.

Much of the research discussed in this part of the review indicated that non-monogamy in MSM relationships created an additional dynamic in MSM's understanding of HIV risk. However, my study seeks to investigate the extent of non-monogamous relationships in the UK context, how/if agreements are negotiated and how these men understand HIV risk in this context.

Negotiation of Safer Sex

Negotiating safer sex with casual or regular sexual partners can be difficult as 'talking about condoms implies both talking about sex and also identifying a potential partner as a risk' (Holland et al., 1998, 10). This has consequences for trust in the relationship, no matter how recent or fleetingly it was. While direct communication was always preferred by sexual health promoters (Rhodes, 2004), there was also an acknowledgement that much of the negotiation happened in a non-verbal manner. In their research, Persson et al. (2015) found that 41.3% of seronegative men and 45.4% of seropositive men who met a casual partner for last sex did not communicate their serostatus. Non-verbal discussion was particularly prevalent in MSM's more anonymous sexual cultures, public sex environments and sex-on-premises venues, where non-communication was encouraged and facilitated (Delph, 1978, cited in Edwards, 2006). However, communication during sexual encounters was vital given that silence about safe sex was often equated with assent for bareback sex by some gay men (Adam et al., 2008). When cues were used instead of direct communication, misunderstandings could arise as many men may not have understood, or may not have the same understanding, of the cue. This gave rise to people engaging in a high-risk behaviour without realising they have done so, or realising after the matter (Adam et al., 2008).

The ability to verbally assert a desire for safer sex may have been more difficult for men who take the receptive role in sex. Research carried out by McInnes et al. (2011) established that taking this role affected the receptive partner's ability to verbally communicate a desire for safer sex. They found that in many sexual settings the receptive partner gave himself over to the active partner and any discussion of condom use in this context would make the receptive partner too assertive/active in the unfolding sexual scenario:

‘this abrogation [of responsibility to the active partner] limits the scope for negotiation, given that assertive requests or negotiations for a condom would detract from a context and a partner who are valued for action, dominance and aggression and could transform [the receptive partner’s] own highly valued passive role into a too-active one.’

(McInnes et al., 2011, 79)

From this perspective, a receptive partner’s ability to negotiate their desire for safer sex was reduced by the role they took. However, not all authors agreed with this view. For example, Lachowsky et al. (2015) found that younger gay men were as likely to use condoms in the receptive role as they were when active. These results reflect earlier findings by Valdiserri et al. (1988) who found that condom acceptability was equal across both roles, with knowledge of a partner’s seropositivity being the only factor that strengthened a receptive partner’s desire to use condoms. While acknowledging that levels of control over condom use varied between the two roles, Teng & Mak (2011) did not find any differences in condom negotiation techniques, suggesting that MSM partners were more equal than heterosexual couples are and used different strategies of negotiation dependent on their sexual role. Therefore, the extent of influence sex role has on condom negotiation abilities remains unclear.

While negotiation of safer sex was particularly important for those who were seronegative, it was also an issue for seropositive men who wished to inform their partners of the risk involved in the encounters with them. Most people who were seropositive expressed a desire to tell their partners of their serostatus prior to sex, as not doing so was seen as being detrimental to their mental health (Ridge et al., 2007). However, while open disclosure would have meant that both partners can have sex with knowledge of the risks involved, it could also have destroyed a potentially pleasurable experience and risk outright hostility. Given the relatively small size of

most MSM communities, this could have far-reaching consequences for the discloser. Stirratt (2005) found that seropositive partners chose to allude to their serostatus instead of a direct disclosure. A variety of techniques were used by seropositive men to indicate their serostatus, such as informing potential partners that they were in receipt of disability payments or worked for an AIDS organisation, or left their antiretroviral drugs in a visible place for their potential partners to see. However, those who used such allusions assumed that potential partners had the same understanding of aspects of the lives of seropositive men. For example, the variety of antiretroviral drugs now available meant that while seronegative men may be familiar with some of them; it was unlikely that they knew every drug available. The growth of internet sites aimed at MSM has also become a way for seropositive men to reveal their serostatus to their potential partners prior to engaging in sex. While some sites allowed for serostatus to be disclosed directly, other sites used various techniques that allowed men to refer to their status without direct acknowledgement. However, even when opportunities for disclosure were present on internet sites, Horvath et al. (2008) found that seropositive men and those who had never tested for HIV were more likely to report being seronegative and only a small number expressed a preference for bareback sex. This indicated a degree of deceit in online profiles and contributed to the established belief that many MSM lie on profiles (Groß et al., 2013). However, other difficulties also arose in the interpretation of information provided on profiles. Adam (2005) carried out research on men's understanding of the term 'safer sex only' on internet sites and found that there were different understandings of meaning between some seropositive and seronegative men. Seropositive men used the term as a proxy for disclosing their status to potential seronegative partners, while seronegative men seen it as an indication that the online persona was stating a need to protect themselves from HIV infection and thereby seronegative. Therefore, both partners think they have revealed enough to believe they were with someone of the same serostatus. In addition, research has shown that men, particularly those who believed they had serosorted, use this term, but had not consistently used condoms or avoided

semen exchange in previous sexual encounters (Prestage et al., 2013). Therefore, this fluid interpretation of 'safer sex only' and the disparity in decoding may have had detrimental consequences for both partners using it, particularly if they were in the process of serosorting.

The body itself can also be used as a means of communicating a desire for safer sex. Hoff and Kamchikanti (2002) discovered four non-verbal means of negotiating safe sex for American seropositive men; directive behaviour, body positioning and environmental and normative cues. Directive behaviour was a manner of moving the partner's body (e.g. pushing a partner's head away during oral sex) or signalling a desire for safe sex, while body positioning occurred when the person used his own body to sexually communicate (e.g. lying on his stomach to indicate a desire for anal sex), giving his partner an opportunity to introduce a condom if he so wished. While they found that the body was not always effective on its own as a manner in which to negotiate safer sex, the authors discovered that when they were used in combination with other cues, they became more successful. Environmental cues, such as leaving condoms and lubricant in a visible place, also asserted a desire for safer sex. However, as discussed above, misunderstanding may have occurred about the meaning of such objects. The partner who made these items visible may have understood this as an indication that no further discussion about safer sex was needed, thereby leaving the choice of condom use to his partner's discretion. Normative cues were described as 'behaviours and external cues that seemed to have universal meaning among gay and bisexual men...these cues were nonverbal yet were clearly understood and tended to direct the sexual encounter' (Hoff & Kamchikanti, 2002, 80). These authors used the example of fingering as an indication for an active partner's desire for anal sex; giving the receptive partner time to negotiate safer sex. However, as with environmental cues, this presumed that both partners have the same cultural capital to understand these cues in the same way.

Normative cues were particularly important in public sex environments and sex-on-venue premises (Somlai et al., 2010). It was in these types of environments where the neoliberal discourse of care for oneself dominated over communitarianism (Parsons & Halkitis, 2002). Research carried out by these authors found that seropositive men were over-represented in these types of environments, because there was less pressure on them to disclose their serostatus. Adam et al. (2008) also found that seropositive men in such environments presumed that others were also seropositive unless they took deliberate steps to engage in safer sex; however the same assumption was not shared by seronegative men. When condoms were not introduced or resisted, seropositive men presumed that this was informed consent for bareback sex, or an attempt at serosorting (Suarez & Miller, 2001). The presumption that everyone you meet is seropositive has been the cornerstone of HIV messages through the years. However, while it was 'originally conceived as a method of hailing seronegative people to practise safe sex, it reappears with some frequency in the narratives of those presuming unprotected sex as a default mode of conduct' (Adam et al., 2008, 768). This suggests that particular types of messages may be important for men after they seroconvert to ensure new infections are minimised.

Much of the literature above examined how MSM negotiated safer sex and the various verbal and non-verbal cues used to inform others of their serostatus and/or negotiate safer sex. The disparity between what was meant and what was understood by these cues presented particular problems for sexual health promoters. However, while there was a particular interest in how men negotiate safer sex, this review indicated a lack of information about how men negotiate unsafe sex and sex more generally. This is particularly important for sexual health promoters as it will highlight what behaviours need to be challenged as much as which behaviours that need to be promoted.

Conclusions

While much research has been carried out in the area of HIV/AIDS since the beginning of the crisis thirty years ago, this review suggested a number of gaps that my research intends to explore. While one of the main aims of sexual health promotion is to inform people of their HIV risk, this research will also investigate how MSM understand and conceptualise this risk in a post-antiretroviral society. There have been many developments in biomedicine recently and how risk is now understood by MSM is of particular interest. If, or how, masculinities influence MSM's understandings of risk is also of importance. Much of the established literature in this field focussed on masculinities as a form of transgression, which may hide many other forms of MSM masculinities. This research seeks to understand the extent of masculinities' influence on MSM's understanding of HIV risk and whether other forms of masculinities influence safer sex practices. In the context of non-monogamous relationships, this research seeks to explore if, and how, agreements within these relationships are negotiated and how HIV risk is understood within this context. While these relationships were often seen as a facilitator of HIV transmission, some literature suggested that the honesty within these relationships created a space for discussions about mishaps, thereby reducing the possibility of transmission. This point will be examined more closely in this research to see how UK-based MSM feel about the effect of non-monogamy has on the risk of HIV transmission. Finally, this research will explore the methods used by MSM to negotiate sex, safe and otherwise. Much of the literature in this area discussed the various cues used by MSM to inform partners of their serostatus and negotiating safe sex. This literature highlighted the potential misunderstandings that can result from these cues. However, my research will explore if MSM in the UK have shared understandings or contradictions in relation to cues used by themselves and/or their previous partners. It also intends to explore how MSM negotiate sex. This is particularly important as it may highlight

behaviours that sexual health promotion may need to challenge, as much as behaviours that need to be promoted.

Chapter Four - Methodology

Introduction

This chapter sets out the methodological approach taken to answer the research question. The method used in this research was an online survey containing a variety of closed, open, attitudinal and vignette questioning and the target audience was sexually active UK-based MSM over the age of eighteen who have had sex with another man within the last year. The integration of both qualitative and quantitative questioning in the survey meant that there was a greater possibility of large-scale nuanced data emerging from this online survey.

The chapter is divided into several sections exploring the various stages of the methodological process. The first of these is an exploration of the advantages of the online method and its justification for use in this research. While other methods were considered, it became clear that the online method provided a series of advantages over traditional surveys for this sensitive research. For example, online surveys have proven successful at reaching difficult-to-access groups from a wide geographical area in a short timeframe (Wright, 2005), allowing for national coverage and providing a snapshot of what was happening within the group at a particular time (Evans & Mathur, 2005). This is particularly important when researching the field of HIV, as developments often occur speedily influencing previously accepted understandings. Internet surveys can also assure respondents of their anonymity, thereby reducing the possibility of socially desired responses (Wang et al., 2005) and reassuring them when answering questions of a sensitive nature (Eynon et al., 2010). However, there were also several drawbacks to this method that needed to be considered. These included difficulties caused by the lack of a sampling frame and the challenge of maintaining respondents' interest in a high-stimulation online environment (Bryman, 2012).

However, these drawbacks were overcome using a variety of specific design techniques, which minimised respondent confusion (Kypri et al., 2004) and kept respondents engaged in the survey to ensure a high completion rate (Bryman, 2012). Stimulus materials were specifically created and integrated into the survey to maintain respondents' interest and allow for nuanced understandings of responses to emerge (Wright, 2005). These included the use of a variety of mass media interventions, self-generated mock profiles and vignette questioning. However, it was equally important that respondents related to these features to reduce any potential respondent dropout at key moments in the survey. It was therefore necessary to pay much attention to the creation of such features to ensure that both the image and/or content were familiar to respondents. Other formats, such as the inclusion of a progress bar, were also utilised to ensure that respondents could sense their progression through the survey.

However, given the sensitive nature of some of the questioning in the survey, consideration had to be given to the wording and the style of such questioning in the survey (Sue and Ritter, 2007). A variety of techniques used in the survey to minimise any potential impact on the respondent were considered (Lee, 1993, Ayling & Mewse, 2009). The results from the pilot survey were of importance to this research, as feedback from these respondents contributed to the final shape of this survey. While constructing an online survey to maintain respondents' interest to ensure a high completion rate was challenging, the integration of a variety of unique features meant that respondent interest could be maintained, even when many sensitive questions were posed.

A discussion of ethics follows, alongside an examination of the challenging issues raised by the Open University Human Ethics Committee in relation to this research. Details are also provided about the recruitment process used to direct respondents to the link for the survey. Given the mixed methods approach, a section discussing the analytic approach to both the quantitative

and qualitative data is presented. In this section, I have shown how I have carried out an integrated analysis and have provided some examples that demonstrates the added value of mixed methods for this research (Moffatt et al., 2006). The combination of both quantitative and qualitative data in this research allowed for the collection of rich, textured data from a large number of people over a very short period of time, which became a strong justification for the use of mixed methods in this research. The chapter finishes with a reflexive discussion about my own role as the researcher and the various ways I could have influenced the research process.

The Online Survey: Advantages and Justification

Online research has grown in popularity over the last number of years alongside the growth of internet take-up and increased broadband speeds. In 2015, 91% of UK homes had a broadband connection and 86% of the population were described as regular internet users (ONS, 2015b). The general growth in internet and broadband uptake has offered significant opportunities for researchers to access a large number of potential respondents and carry out both quantitative and qualitative research without the time and cost constraints of traditional research (e.g. Davies et al., 2004; Marcus et al., 2012). This was particularly important for this research as it increased the likelihood of being able to access difficult-to-reach groups from a wide geographical area (Wright, 2005). The online survey has also proven to be valuable for accessing MSM as they are ‘the population most infected and affected by HIV [who] appear also to be early and enthusiastic adopters of the internet for sexual and non-sexual communication’ (Pequegnat et al., 2007, 506). In addition, research has also shown the internet method is particularly valuable in reaching high-risk MSM who actively avoid participation in venue-based research, because they may feel more anonymous in an online environment (Raymond et al.,

2010). With Gaydar now having a multimillion pound turnover (Mowlabocus, 2010), 76% of MSM using internet platforms to source partners in the previous six months (European MSM Internet Survey, 2015) and Grindr receiving over one million logons worldwide daily (Avery, 2013), it is conceivable to suggest that MSM have greater access to, and familiarity with, the internet than other groups in the wider population. Research has also shown that 14% of MSM are now exclusively seeking their partners online, highlighting the limitations of venue-based research for this project (Rosser et al., 2009). Internet research can reach other hidden populations such as younger MSM, rural MSM, those who do not attend MSM-orientated venues and those who specifically organise online, such as BDSM groups and barebackers (Tsui & Lau, 2010; Raymond et al., 2010; Miller & Sonderlund, 2010). It is therefore reasonable to suggest that the online survey presented greater possibilities to reach the audience for which this research was intended.

There are two types of internet survey, online and email surveys. However, the online survey had several advantages over its email based counterpart for this research. As there was no sampling frame to work from, the email survey was deemed impractical. Online surveys also have advantages over email surveys in that they can be formatted in a way that makes them more interesting for respondents and can include filter questioning, which direct respondents to the next relevant question without the need to provide further information, thereby avoiding logical inconsistencies (Wright, 2005). In addition, email surveys raise issues of anonymity for respondents, which given the sensitive nature of the topic and the relative size of some close-knit MSM communities, was essential for the successful completion of this research. As Sue and Ritter (2007, 5) point out, 'participants who are to respond to a questionnaire by replying to an email will lose their anonymity...if, however, participants are directed to a website to complete the questionnaire, some measure of anonymity can be promised'. However, anonymity was

also important as it had the potential to reduce socially desirable responses (Wang et al., 2005). This was particularly relevant to the condom code, which is heavily endorsed within MSM communities. It was hoped that respondents would feel less pressure to maintain the condom code in an anonymous online survey than in face-to-face interaction.

One of the primary advantages of the online method is the speed and ease of data collection. The online survey allows researchers to capture the opinions of a large number of respondents from unique populations sharing common characteristics within a short timeframe despite large geographical distances between respondents (Wright, 2005). As such, data was collected from all parts of the UK, which allowed for national coverage without the need to spend time sourcing respondents, travelling, recording responses etc. This short timeframe also afforded the research a precise snapshot of what was happening with MSM, without the time lag present in the traditional survey method. This was especially important for researching in the field of HIV, as the pace of developments means that facts and understandings can change quickly. Indeed, during the course of the instrument construction, two major developments in the field of HIV occurred in the UK. The first was a greater awareness of the PROUD study within the gay communities and the second was a change in law allowing for the introduction of HIV home testing kits¹⁷. Therefore, the upfront time taken to construct the survey allowed me to integrate these topics into the survey and question respondents on the most current developments in the field. The pace of data collection also meant that results were generated in a much timelier manner than other forms of research.

¹⁷ The law regarding HIV home testing kits was changed in August 2013. This change allowed for patients to test and receive results of a HIV test in their own homes and were introduced in April 2014. Prior to this, home testing kits were available, but testers needed to post the kit to a laboratory before getting results.

The speed at which internet survey software is developing, and the technological advances made by newer computers, meant that this online survey was administered very quickly and results were automatically tabulated for analysis in IBM® SPSS®, thereby reducing time spent on coding and inputting data. The method also allowed the survey to be constructed to encourage respondents to answer a set of questions (a) before progressing, thereby minimising non-response, and (b) in the order intended by the researcher, reducing survey bias (Evan & Mathur, 2005). However, given the sensitive nature of this research, it was decided that the number of compulsory questions should be kept to a minimum. This allowed respondents to answer questions they felt comfortable with, whilst also allowing them the freedom to progress with the survey if a specific question raised uncomfortable issues for them.

However, while there are many advantages to the online method, the drawbacks of this method were also considered. One of the main drawbacks for online surveys is the lack of a sampling frame and the limitations this imposes on the sampling method that can be used. As the use of a probability sampling method is ruled out, the representativeness of the survey may be called into question. However, while many authors have suggested that the findings from unrepresentative studies will only be generalisable to the population from which the sample was taken, as demographic details were collected in the survey, it was possible to compare the group who have completed this survey with what is known about the MSM population more generally. In addition, Scholl et al., 2002 (cited in Evans & Mathur, 2005, 197) state that 'when most of society has internet access and savvy, the basic drawback for the use of online survey research – the lack of representativeness – disappears'.

The form of non-probability sampling used in this survey was a two-stage purposive/convenience sampling method. Purposive sampling is one 'where a selection is made

based upon a known characteristic' (May, 2011, 100) and is commonly used to research difficult-to-reach populations with specialised information. As the target audience for this research was sexually active UK-based MSM over the age of eighteen who have had sex with another man within the last year, this sampling method was deemed the most appropriate for this work. Within this sample, a convenience sampling method was used, which is defined by Neuman (2003, 211) as methods in which one 'gets any cases in any manner that is convenient'. However, recent research has pointed out that convenience samples tend to over-represent MSM who identify as gay and those who are more likely to engage in high-risk sexual behaviours (Prah, et al., 2016). Nevertheless, while these forms of non-probability sampling have many drawbacks, it allows for this research to be used as a catalyst for further research and for links to be made with established findings in the area.

Enticing people to the survey in a media saturated online environment is one of the key difficulties for online research. For example, Twitter was used as one of the ways to disseminate the survey to potential respondents and I was aware that my tweets about the survey may have been become lost on followers' timelines. While there was a temptation to constantly tweet a link to the survey in order to avoid this disappearance, I was also aware that my tweets about the survey had to be interspersed with other tweets in order not to frustrate or alienate potential respondents. Therefore, a delicate balance had to be maintained. A second blank Twitter account was also created to target specific groups or individuals for retweets. This potentially doubled the reach of the survey, while reducing possible annoyance from my own Twitter account. In addition to dissemination through Twitter, an individual Facebook page for the survey was constructed and promotional advertising was purchased. A target audience for the survey was created in Facebook and links to the survey were promoted on targeted user's

profiles. Pressing the link to the survey was optional for such Facebook users, so only interested potential respondents are likely to have clicked the link.

Design of the survey

This survey used a combination of open, closed, attitudinal and vignette questions directed at each of the research topics that derived from the literature. Including both quantitative and qualitative methods in this research aided completeness and ensured that the whole was greater than the sum of the parts. While the *embedded methods* and *paradigm* arguments argue against combining quantitative and qualitative methods, mixed methods research has grown in popularity over the last number of years alongside the importance of triangulation for the validation of research (Bryman, 2012). The mixed method approach in this work helped to 'broaden the dimension and scope of the research, allowing for a more robust explanation of the processes being investigated and, ultimately, the development of a more holistic picture of human behaviour' (Mayoh et al., 2012, 23). Open-ended questions in the survey gathered qualitative data from a much larger sample than is achievable in other types of qualitative research (Robson, 1993). By including open questions, respondents were also able to offer their own accounts in their own words. Without the presence of an interviewer or other respondents, 'survey participants [who] use the same terms in their responses [to open questions]...provide compelling evidence for culturally shared understanding of the issue under research' (Toerien & Wilkinson, 2004, 71). Therefore, this survey not only asked respondents about how they understood risk and negotiated sex, but also accessed data on the manner in which they themselves constructed their own sexual experiences.

Keeping Respondents Engaged

The internet is an environment where users are accustomed to high stimulation and it was imperative to maintain respondents' interest in the survey to ensure a high completion rate. However, the survey was constructed keeping in mind Bryman's (2012) suggestions that they should be innovative, making maximum use of various stylistic formats and visuals to entice respondents and keep them interested while completing the survey. Research carried out in the UK by Evans et al. (2004) showed a 70% completion rate for a similar non-compensation online sex survey which had 150 questions and took 20-30 minutes to complete. However, this completion rate is considered high in comparison to other surveys in the field (Sills, & Song, 2002). Therefore, to achieve the highest possible completion rate, it was crucial that a wide variety of design techniques were utilised to maintain respondents' interest. The following sections of the chapter will deal with each of the key features used and the impact this may have had on encouraging respondents to complete the survey.

Design Specifics

One of the primary aims to maintain respondents' interest in the completion of the survey was the use of brief, direct questions on the topic. While this ideal was kept as a guide throughout the survey, the complexity of MSM's negotiation techniques meant that this was not always feasible. Where complex terms were used, definitions were provided at the start of the page in the hope that questions were direct and precise.

Pre-exposure Prophylaxis (PrEP) Trials

Definition of 'PrEP': Currently on trial in the UK, PrEP is HIV medication that is taken by negative people in order to prevent them from acquiring HIV. It is different to PEP (post-exposure prophylaxis) in that the drugs are taken *before* potential exposure to HIV. In order for PrEP to be effective, it must be taken consistently and has a number of potential side effects. PrEP is intended to be taken over the short term with people coming off it when they believe that they are at a lower risk of HIV.

54. Given the definition above, I think PrEP will...?

Online surveys also have the advantage of facilitating automated branching that direct respondents to the next relevant question based on their responses to previous questions (Kypri et al., 2004). This avoids the confusion caused by directions on paper surveys. For example, separate questions were constructed according to revealed serostatus, relationships status etc. This progressive focussing allowed for increasingly specific questions to be asked of respondents according to their own personal situations. This was crucial for understanding the issues directly related to each sub-group in how they understood risk, negotiation etc. and provided a wealth of information that cannot normally be gained from traditional surveys. In addition, automatic skips allowed branching to happen without the need to direct respondents, thereby avoiding logical inconsistencies and creating a flow within the survey. Therefore, respondents only faced questions that were directly relevant to them. Other interactive features were employed, such as the use of earlier responses to tailor questions as the survey progressed. For example, respondents were asked how often they had a HIV/STI test [Q.25] and this response was subsequently filtered into the following question relating to why they tested at that frequency. In this case, the question was specifically created according to the respondent's previous answer.

Frequency of HIV/STI testing

25. I have a HIV and/or STI test approximately...

☐ once every 3 months

☐ once every 6 months

☐ once a year

☐ less frequently

26. Why do you test [Q25]?

- ☐ Given my sex life, I believe this frequency is the best for me
- ☐ Generally, I do not put myself at risk of HIV/STIs
- ☐ I am in a long term relationship
- ☐ I follow guidance from my doctor/clinician
- ☐ I follow the recommended guidelines

Other (please specify)

However, caution was exercised in relation to the number of these features used in the survey as respondents may not have had the appropriate software necessary to facilitate specific features leading to respondent frustration and increased dropout rates (Dillman et al., 2009). This highlighted the importance of piloting for the survey. While I had concerns about the extra seconds taken to move from question twenty-five to twenty six, respondents to the pilot commented on the technology that allowed for the increased specificity of questions, rather than the time taken to move from one question to the next.

Sensitivity and Questionnaire Wording

Overcoming issues related to the sensitive nature of the research topic was particularly important for the successful completion of this research. Sue and Ritter (2007) suggest two techniques that were used in the survey to minimise the extent of socially desirable answers. The first is to reiterate the promise of confidentiality and anonymity stated in the informed consent. Such a restatement was placed at the beginning of questions about monogamy and relationship status in order to reassure respondents that everything possible was done to keep their responses anonymous and confidential.

What monogamy means to you

Before asking you questions about your own relationship/s, I want to explore what monogamy means to you. *You can answer these question whether you are in a relationship or not.*

Remember, in line with the information provided in the informed consent, every step is taken to protect your anonymity and confidentiality when answering questions in this survey.

However, as some of the responses to the section on mass media interventions may be seen as critical of certain sexual health organisations' work, I felt that it was also important to distance myself as a researcher from such organisations in order to allow respondents freely express opinions on the images used.

Sexual Health Messages

The following pages contain a number of questions about specific sexual health messages (adverts about condoms, safer sex etc.). However, before being introduced to these, I want to ask a number of questions about sexual health messages more generally. ***Remember, I do not work on behalf of any sexual health organisation, so feel free to express your opinions openly.***

In addition, assuring respondents that their behaviour is not unusual by use of an authoritative source can encourage people to be more open about their own behaviours (Bryman, 2012). For example, before asking about their own barebacking practises, respondents were advised that a recent survey had indicated that over seventy percent of those respondents had previously engaged in bareback sex. It was thought that phrasing sensitive questions in this manner could encourage men to be more open about their sexual practices in the survey. Such techniques were utilised to minimise the need for respondents to feel compelled to answer questions in a socially desirable manner.

A great deal of consideration was given to the question relating to a respondents' serostatus. Even within the MSM communities, HIV-stigma remains high (Mahajan et al., 2008). While a

direct question may have isolated some respondents, especially at an early stage of the survey, guidance was taken from HIV organisations on how best to ask this sensitive question. It was deemed that a question about whether or not the respondent ever had a HIV test was a non-intrusive way to pose a question about serostatus.

HIV Testing

*27. Have you ever received an HIV test result?

- ☐ No, I have never received an HIV test result
- ☐ Yes, I have tested positive
- ☐ Yes, my last test was negative
- ☐ Rather not say

Asking sensitive questions in questionnaires is always problematic. However, building on research carried out by Sudman and Bradburn (1984), Lee suggests that 'open questions should be preferred to closed and long questions to shorter ones' to elicit frank responses to questions (1993, 76). Open questions are recommended for questions relating to frequency of behaviour, as respondents tend to avoid extreme category responses. When asking questions about behaviour, longer questions are preferred, as these allow respondents time to recall events that may be relevant to the question. A similar technique was successfully used by Ayling & Mewse (2009) in online interviews of gay men and their sexual practises. However, long questions can induce fatigue and the number of open questions had to be minimised in the survey to keep it within an acceptable timeframe for respondents. In addition, as mentioned earlier, the internet is an environment where users are accustomed to high stimulation and my aim had to be to keep the questions on the survey as brief and direct as possible. Therefore, while these techniques were successful in online interviews, their practicality for this online survey was limited.

However, this does not mean that longer questions, to help respondents reflect and consider responses, were not incorporated into the survey. One example of the longer questions used in this survey was the use of the vignette questions about Juan, an imaginary friend of the respondent. As respondents to sensitive questions may feel their responses were being judged by the researcher, Finch (1987) recommends that vignettes should be constructed about other people to create distance between the respondent and their response, in this case their friend, Juan. However, there is no complete agreement over the effectiveness of third-person scenarios in vignettes, as respondents may recommend actions that they would not necessarily carry out themselves. However, even if respondents related to the individual in question, responses were hypothetical and may not have reflected what they would actually do in such a situation.

Lee (1993) further recommends that familiar words should be used in the questionnaire to make the respondent feel more relaxed and help them with their understanding of the question. For example, while the phrase 'unprotected anal intercourse' is still used in medical literature to describe barebacking, the term is unlikely to be familiar to many MSM. Therefore, more commonly used terms such as 'bare', 'bareback' or 'raw' may have been used. However, researchers must be careful with balance in the usage of such terms. Commenting on the use of the term 'anal fucking' instead of 'anal intercourse', a respondent to Huby and Hamer's (1994) HIV needs assessment in prisons stated:

'The research you are doing is in a good cause but the way you have written the questions is bad. Just because I'm in jail, it doesn't mean I talk filth.'

(Huby & Hamer, cited in Hughes, 1998, 389)

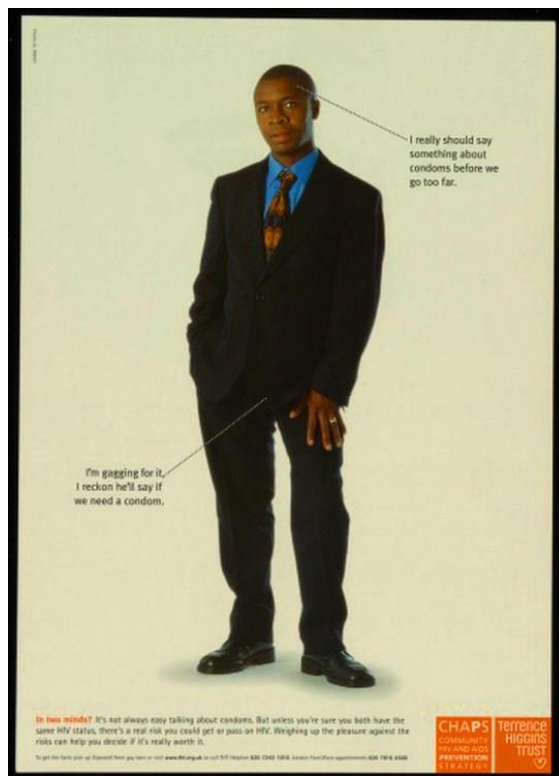
However, it was decided that 'bareback' would be used most frequently throughout the survey with the term 'bare' only used on one occasion ('fucking bare is a real turn on'). In this instance, it was thought that the colloquial nature of the phrase meant that the term 'bareback' may have

seemed too forced or unnatural. As the term 'raw' is more associated with more extreme sex, it was decided that it would be inappropriate to use in the survey as it may have raised uncomfortable issues for some respondents and may have needed further explanation for those not familiar with the term.

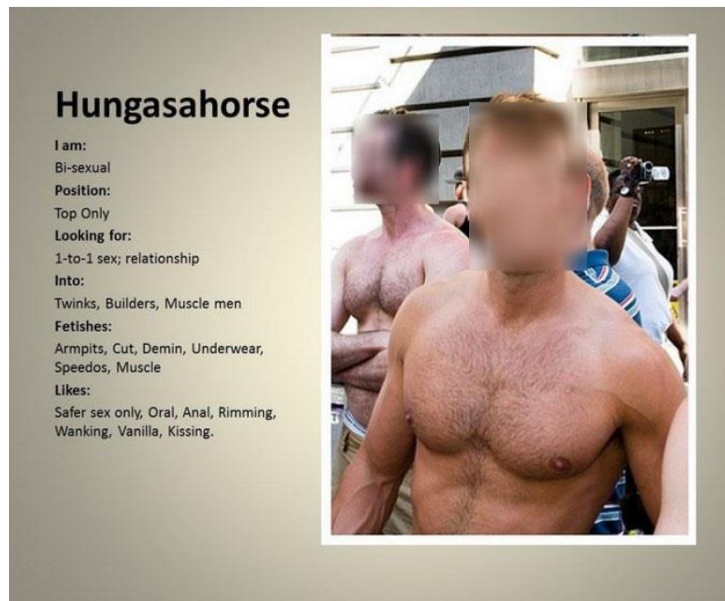
Developing and Using Stimulus Materials

Stimulus materials, such as visuals and quotes from mass media interventions, were used in the survey to maintain respondents' interest in completion and provided a robust basis for making comparisons, since they contextualised responses¹⁸. A wide number of such mass-media HIV prevention interventions were considered for this purpose. However, these were reduced in number and the final five were chosen to reflect the variation in the communities in terms of age, ethnicity, marital status etc. For example, the 'I really should say something about condoms' image was chosen not only because of the ethnicity of the man in the image, but also because he was wearing a wedding band. Therefore, this image had a dual purpose of representing the Black British communities in addition to being inclusive of married men in the survey. This image is presented below:

¹⁸ All screenshots in this chapter are taken from my survey, which was created on SurveyMonkey™ Inc., Palo Alto, California, USA. www.surveymonkey.com Full references for screenshots and images can be found in the appendices.



In addition to these materials, mock online profiles were carefully created to interrogate respondents' reading of such profiles. This was particularly important for understanding how respondents read or understand another man's serostatus from such profiles. Guidelines were taken from profiles from a variety of online and mobile applications' profiles to ensure they looked and felt familiar to respondents. From this investigation, several key descriptors emerged such as fetishes, sexual role and preferences, and these were included in the mock profiles. The most commonly used words and phrases were also taken from numerous such profiles to construct the chosen mock profiles. Furthermore, the pictures for the profiles were selected to reflect the images used by men seeking sex with other men. It was important that respondents felt that these images were 'real' and reflected something they were familiar with. Otherwise, there was a potential that they could have become isolated and disengaged from the survey.



In order for the respondent to be able to estimate how much time was needed to complete the survey, a progress bar was also visible in the survey. It was hoped that these actions would provide an interesting and entertaining survey that would minimise frustration and provide clear guidance to respondents as to how long it will take them to complete the survey.

Vignette questions were an important element of the survey as a means of interrogating attitudes towards safer sex. According to Hughes and Huby (2001, 382), vignettes are a 'form of text or pictures presented to research participants to prompt responses to questions'. In their study of risk behaviours of drug users, McKeganey et al. (1996) concluded that providing vignettes made respondents feel more comfortable in reporting their risk behaviours than asking questions directly. The authors felt that their respondents, in this case drug users, may have felt that there was an underlying assumption that s/he disregards their own/others' health in direct questioning. However, 'in the vignettes, by contrast, there is an implicit recognition of the potential for the injectors' behaviour to be constrained by the social context within which the drug use is occurring' (McKeganey et al., 1996, 562). Considering this argument, the vignette

used in the survey presented respondents with two scenarios on separate pages and asked them how they would respond if their friend, Juan, was in a specific scenario¹⁹. In doing so, the vignette explored respondents' normative judgements and standards in certain situations. The unfolding nature of the vignette gradually increased the specificity of the initial scenario and invited respondents to reflect upon their judgements as the situation unfolded and developed. In this manner, a history and a context were added to the scenario, which enabled the respondent to understand a more complete story.

Piloting

While piloting is particularly important for any self-completion survey, it was crucial for this survey as it had the dual purpose of refining the questions and the instrument design specifics, particularly because a number of designs suggested had not previously been incorporated in online surveys. Issues such as poorly worded and confusing questions, inappropriate wording, threatening questions etc. became apparent during the process. One respondent to the pilot study stated that he wanted to stop the survey because it made him reflect upon his own risk-taking, something he became uncomfortable with. Based on this feedback, I identified the questions most likely to be challenging for respondents and placed them towards the end of the survey in line with Lee's (1993) recommendations. The pilot also highlighted problems with design specifics. While it was originally thought that the mass media interventions could be disturbed throughout the survey to maintain respondents' interest in completion, respondents to the pilot were left confused by their distribution and felt they interrupted the overall flow of the survey. As a result, the mass media interventions were clustered together into a one new section at a midpoint in the survey. It was hoped that their new location would cause less confusion, yet still provide some stimulus after answering some of the initial questions of the

¹⁹ See appendix four

survey. The other images used in the survey, the mock profiles, were included during the latter stages of the survey for a similar purpose.

However, the main issue to arise from the pilot was the length of time taken to complete the survey. Throughout the survey construction process, it became clear that the number of questions asked were too great to keep within an appropriate time limit for an online survey. This was further complicated by the number of branches and the particular routes respondents could take through the survey. For example, respondents who were in relationships faced considerably more questions about the nature of their relationship(s) than those who were single. Similar branches took place throughout the survey making time estimation for completion of the survey particularly challenging. In addition, answers to open questions could not be estimated because of variations in length of responses and respondents' typing speeds. Nevertheless, it was clear that compromises had to be made to achieve a moderate completion rate. The survey was revised and only those questions that could be justified and were directly related to the research topics were retained.

- Only one of three vignette questions were kept. While the other two vignettes were directly relevant and could have contributed to the research, feedback from the pilot suggested that they took too long to read and for responses to be considered. The shortest of these vignettes was retained, as it did not require any definitions for respondents (such as PEP) and was the only way I could see of investigating the eroticisation of HIV.
- The number of mass media interventions used was reduced from eight to five. The other images could have contributed to a wider discussion, particularly as one of these gave instruction on how to reduce risk when barebacking. However, as time was a primary concern, these had to be removed from the final version of the survey.

- The number of mock profiles were reduced from three to two. While it was originally thought that there should be one profile for each of a *suggestively* seropositive, *suggestively* seronegative and status-unclear character. It was decided that the *suggestively* seropositive profile was to be removed, as the remaining two could contribute more to a discussion on how MSM read such profiles.
- Several open questions were closed or removed. This was done to reduce the time taken to fill in responses to open questions.

Piloting is also specifically important for internet surveys to highlight any difficulties with the survey design issues on different operating systems. However, the survey was tested on a variety of operating systems without problems and the issue was not raised by respondents to the pilot. Therefore, I was confident that this survey would work well on a variety of operating systems.

Ethics

In addition to following ethical guidelines established for traditional surveys, online surveys must also follow those established in relation to internet research. This is an evolving area with new ethical difficulties arising as more research is carried out online. In as much as they can, confidentiality and anonymity were guaranteed to all respondents, which is particularly important when the research topic is considered controversial or sensitive in nature (Eynon et al., 2010). However, the nature of online surveys means that anonymity and confidentiality can never be completely guaranteed. Nevertheless, respondents were assured that every step was taken to protect their data:

What will happen to the information you share with me?

Ethical Guidelines from the British Sociological Association (2002) and those specifically targeting online research will be followed throughout this research. As this is a web-based survey, responses cannot be considered completely anonymous. However, every step is taken to protect your anonymity and any information supplied in the survey that may identify you will be removed. Similarly, confidentiality of the data cannot be absolutely guaranteed, but all electronic data will be stored as password-protected files, and deleted three years after the submission of my PhD. Subsequently, extracts from your survey responses may be quoted in my thesis and in any publications or presentations arising from the research. Both the Data Protection Act 1998 and the Freedom of Information Act 2000 will be complied with for this research.

In line with guidance from Nosek et al. (2002), 'the use of encryption and secure socket layer (SSL) protocols [and the] use of data labels that are meaningless to anyone but the researcher' was followed. As networked computers may have left the data open to possible security breaches, a password protected, encrypted laptop was acquired from the university to ensure that only the researcher was able to access the data.

Bruckman (2002) stated that each sub-element of the consent form is gone through one stage at a time to ensure consideration of each element. This was a compulsory question in the survey and respondents had to agree with all responses in order to proceed with the survey.



MSM Survey

Consent to participate in this research

☐ 5%

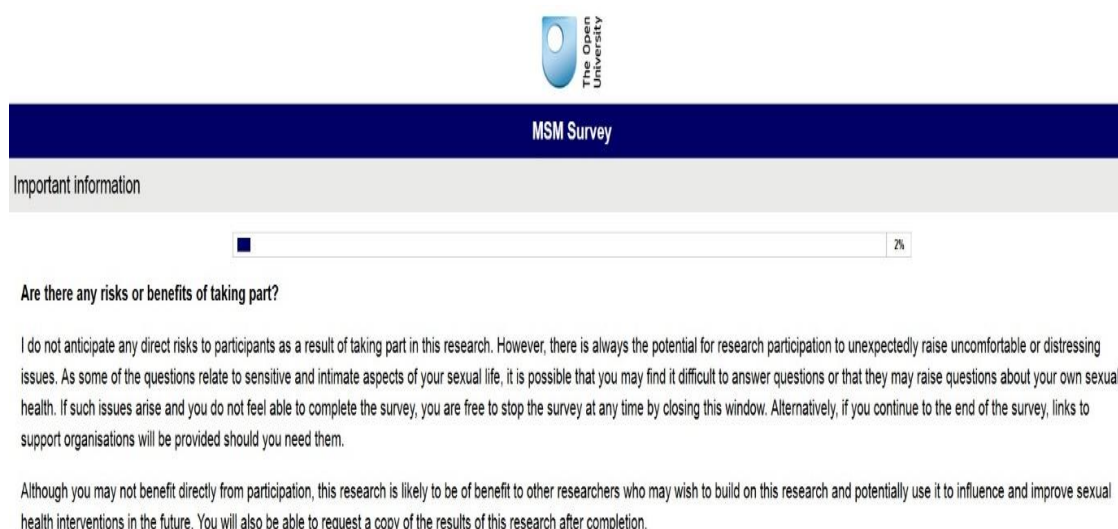
I hope you will complete the survey as fully as possible, as it will help me with my research. *I do not work on behalf of any of the sexual health organisations mentioned in this survey, so feel free to respond as openly as you wish about their work and your sex life.* The survey is in several sections. Please read the instructions carefully. When filling in the questionnaire, please tick the box that most accurately represents your answer, or fill out the space provided in your own words.


*2. To begin, read the following statements and check the appropriate boxes:

- ☐ I am aged 18 or older
- ☐ I am a man who has had sex with another man (anything from masturbation to anal sex) in the last 12 months
- ☐ I am currently resident in the United Kingdom
- ☐ I understand that by completing this survey (submitting my answers electronically) I agree to take part in this research under the terms indicated in the information supplied

Prev Next

In respect to harm, the BSA Statement of Ethical Practices (2002, 4), states that researchers 'should attempt to anticipate, and to guard against, consequences for research participants that can be predicted to be harmful.' Given the sensitivity of the subject, respondents had the option to opt-out of the survey at any stage. Respondents were made aware of the sensitivity of the subject matter of this survey in the 'Important Information' section, which formed part of the informed consent, and notified that they were free to stop the survey at any stage if they became distressed. They were also made aware that links to support organisations were available after completion should they have become concerned about their own sexual health as a result of completing this survey.



 MSM Survey

Important information

■ 2%

Are there any risks or benefits of taking part?

I do not anticipate any direct risks to participants as a result of taking part in this research. However, there is always the potential for research participation to unexpectedly raise uncomfortable or distressing issues. As some of the questions relate to sensitive and intimate aspects of your sexual life, it is possible that you may find it difficult to answer questions or that they may raise questions about your own sexual health. If such issues arise and you do not feel able to complete the survey, you are free to stop the survey at any time by closing this window. Alternatively, if you continue to the end of the survey, links to support organisations will be provided should you need them.

Although you may not benefit directly from participation, this research is likely to be of benefit to other researchers who may wish to build on this research and potentially use it to influence and improve sexual health interventions in the future. You will also be able to request a copy of the results of this research after completion.

In order to minimise the possibility of respondents completing the survey in inappropriate settings, they were also provided with information about the content of the survey and when it might be inappropriate to complete it.

Other important points to consider:

You may not wish to complete this survey in the company of others for the following reasons:

- Some of the images used may be considered 'explicit' in nature.
- Questions ask about intimate aspects of your sex life and/or relationship

Therefore, it may not be appropriate to complete this survey in front of minors, people who may be of a sensitive nature and/or partners.

If you use a shared computer and wish to minimise the possibility of someone tracking your responses, it should be noted that there is no way to completely remove your movements online. Information on how to minimise this possibility on the most commonly used browsers is given at the end of the survey. However, it should be noted that removal of history/cleaning cache may have other consequences on your computer, such as erasing saved passwords, so user discretion is recommended.

I was particularly aware of the difficulties some respondents may have in completing a survey of a sensitive nature on their own personal computers. The growth of internet fraud has led to a greater awareness of identity theft and the ability of others to trace online movements. This was deemed to be particularly important for respondents who were not fully 'out' to family/friends/employers/wives and those who did not want their responses divulged to their primary relationship partners etc. Respondents were informed that directions on how to clear the history and cache from their computer to minimise the possibility of their responses being tracked by others was provided at the end of the survey. However, it was made clear to respondents before starting the survey that there was no way to completely remove their movements and that removing their history and cache may have other consequences for their computers. Instructions on how to remove the history/cache contents from the five main internet browsers was provided at the end of the survey.

Clearing history/cache

As mentioned in the introduction, there is no way to completely remove your movement online, but following these steps can minimise this risk. However, as highlighted earlier, removing history can have consequences for saved passwords on your computer, so you must adjudge which is the greater risk for you.

The five main browsers are listed below. However, there are many different versions of these browsers and the instructions may vary according to the version you use. If the instructions given do not work or if you use a browser other than the ones listed, a quick search of 'clear history in (browser name)' should reveal details of how to remove your history.

***218. Firstly, you must tell me which of the following browsers you are using. If you are unsure, click 'Help' or 'Tools' on the toolbar on the top of the screen. There you should find options such as 'about firefox' or 'about internet explorer' etc. This should tell you what browser you are using. I am using...?**

- ☐ Chrome
- ☐ Firefox
- ☐ Internet Explorer
- ☐ Opera
- ☐ Safari

If respondents wished to subsequently withdraw from the research after completion, they were also informed of this opportunity before starting the survey. The final question of the survey invited respondents to create a unique code so that they could be identify their responses in the dataset. They could use this code to email me to request they be removed from the research. One respondent used this option. However, the person admitted that she was a researcher with an interest in online survey construction and had used the survey to further her own knowledge of the subject. Her responses were subsequently removed from the dataset. No other respondents made use of this option.

How do I withdraw from the research?

If you decide you want to withdraw from the research please contact us via email (see below) quoting the unique participant code you will be asked to create before completing the survey. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my dissertation. Therefore, I strongly encourage you to contact me within a month of participation if you wish to withdraw your data. I'd like to emphasise that participation in this research is voluntary and all information provided is anonymous where possible.

It was hoped that all these steps would reassure respondents that they could complete this survey in the confidence that all necessary measures were taken to protect their data.

Ethics and the collection of Sensitive Data

Given the sensitive nature of this research, a number of ethical concerns were raised. In the first instance, the sexual nature of this topic may have been seen to invade the private and intimate lives of MSM. However, while there was much concern about privacy in the 1970/80's, Lee (1993, 20) suggests that 'it would be difficult to assert that such inhibitions remain as strong as they were [then]'. Recent results from the National Survey of Sexual Attitudes and Lifestyles (2013) showed that less than 3% of respondents refused to answer the most sensitive sexual questions on their survey, in comparison with 20% who refused to answer questions about income (Clifton, 2014). These results suggest that respondents to surveys are more willing to report details of their sexual behaviours than previously thought. In addition, the particulars of MSM's sexual lives have become very public since the advent of HIV/AIDS and the subsequent upsurge in MMI, which suggests that they may have been more willingly to discuss their sex lives than others. However, given that the discourse of MSM's sex lives has been dominated by safer sex discussions, it may be that this is the only way some MSM feel they can discuss their sex lives. Therefore, this might be one of the possible explanations for the differences between the reported and actual behaviour of respondents.

Nevertheless, I was aware of the inhibitions and difficulties some men, particularly those who are married to women or have recently come out, might have when talking about matters that are sexual in nature. As discussed earlier, careful consideration was given to the variety of terms that could be used to represent unprotected anal intercourse in the survey. In addition, other terms had to be clarified to minimise confusion about definitions. For example, the term 'giving head', a term widely used for oral sex, was defined as 'sucking him'. Definitions were also provided throughout the survey for more technical terms that respondents might not have been familiar with, such as 'undetectable viral load', 'PrEP', 'PEP' etc. to ensure all respondents had

the same understanding of such terms. While some of these medical terms were quite complex and difficult to explain in lay language, guidance was taken from selected sources (e.g. Terrence Higgins Trust) to ensure that such definitions were as clear as possible.

There was also the possibility that this research may have induced anxiety as respondents reflected upon their own risk-taking that was at odds with the condom code. This was an issue raised by one of the respondents to the pilot survey. In order to reduce any alleviate any anxiety caused by the survey, a number of links to specific sexual health websites and details of helplines were provided at the end of the survey for each respondent. Links to private sexual health clinics and websites promoting HIV home kits were also provided for those who did not wish to attend more public health settings. As PrEP was discussed in the survey, it was deemed that a link to the PROUD study would be appropriate for those who may have considered this as an option for their sex lives.

Issues Raised by the Open University Human Ethics Committee (OUHEC)

Several pertinent issues were raised by the OUHEC in relation to this research. Reservations about the sensitivity and the personal nature of the questions raised many concerns for the committee. In this section, the primary concerns of the OUHEC will be raised and I will discuss how a resolution was reached on these matters.

The chief concern for the committee, and myself as a researcher, was the possibility that a respondent might reveal information about engaging in illegal activities during this survey. For example, a respondent may have revealed details of encounters with people under the age of

consent or that they had intentionally and recklessly transmitted the HIV virus to another person. While this information could have been potentially revealed in any open question should a respondent have wished to, a question about how respondents defined 'hot sex' was deemed most likely to provoke such a response. When my own concerns about this possibility was brought up with the OUHEC, major concerns were raised about progressing with the survey. In addition to seeking legal advice on the law of the intentional/reckless HIV transmission, two of the key recommendations suggested by the panel were to a) place a notice before the question informing respondents about illegal activities (in addition to such a notice at the start of the survey) and b) remove the majority of the demographic questions from the survey so as to reduce the possibility of a respondent being identified.

The primary purpose of the 'hot sex' question was to encourage respondents to reflect on their sexual ideals or fantasies, which may have laid outside of the 'condom code'. Therefore, a degree of spontaneity was required to allow respondents to answer this question truthfully. To place information about illegal activities directly before this question would have been detrimental to the purpose of the question. In addition, the question was carefully worded to ask respondents to exercise their imagination rather than to report on actual behaviour. Therefore, respondents were free to report behaviour that they may never have engaged in.

In addition, it could be argued that there is a lack of awareness about the intricacies of the law on deliberate/reckless transmission of HIV, particularly among the seronegative communities for whom it does not apply, unless they find themselves in a situation where they have been infected in such a manner. Therefore, it could be argued that to place a warning directly before such question would be likely to induce anxiety or distress in respondents who may confuse the

act of barebacking with illegality. As point 28 of the British Sociology Association Ethical Guidelines (2002) states (emphasis my own):

‘Members should consider carefully the possibility that the research experience may be a disturbing one and *should attempt, where necessary, to find ways to minimise or alleviate any distress caused to those participating in research*. It should be borne in mind that decisions made on the basis of research may have effects on individuals as members of a group, even if individual research participants are protected by confidentiality and anonymity.’

Therefore, it was contended that to place a warning about illegal activities before the question would have been detrimental to the question’s purpose and would raise another ethical issue regarding distress. The panel were also reassured that the focus of analysis was on a preference for bareback sex and indicators of how masculinities influence sexual behaviour. Any information that indicated a preference for sex with minors, which did not happen, would not have been used in the analysis.

The suggestion that the majority demographic information from respondents should not be collected was robustly defended. For example, it was imperative to know the age range of respondents to understand their beliefs about safer sex. How young MSM understood their risk of acquiring HIV may have been significantly different from how older MSM understood that same risk. To collect information about a monolithic group of MSM and not have such essential information would be detrimental to the overall research. However, to collect this essential information about MSM while maintaining respondent anonymity, several compromises were made. Several ‘*rather not say*’, ‘*none of the above*’ and ‘*other*’ options were included to close questions and allow respondents to opt out of detailing responses they felt uncomfortable

giving. This was particularly important for respondents from smaller urban and rural locations. However, an open question for those born outside of the UK asking them to state their country of origin was deemed essential as significant variation in HIV prevalence occurs between countries throughout the world. However, respondents could proceed with the survey without completing a response to this question if they so wished.

The law concerning the reckless transmission of the HIV virus was a particular concern on which the OUHEC recommended legal advice be sought. The variation in Scottish law posed particular problems for this research. While in the other countries of the United Kingdom, actual transmission must be proven for a successful prosecution, the anomaly does not exist in Scottish law. Hence, if a seropositive respondent living in Scotland had stated that he knowingly had unprotected sex with a seronegative man where there was likelihood of transmission, this could have left him open to potential prosecution under Scottish law. However in order to clarify this understanding of the law, legal advice was sought from Professor James Chalmers at the School of Law at the University of Glasgow. In email correspondence (29th of October 2013), he stated:

“If a respondent to your survey were to admit that they had (in Scotland) engaged in unprotected sex whilst HIV-positive and without their partner knowing this fact, that would in theory amount to admission of a criminal offence, although those bare facts alone would not amount to conduct which the official policy suggests prosecutors would consider worthy of prosecution. In England, this would not amount to an admission of a criminal offence, although it would suggest that a criminal offence could potentially have taken place. In practical terms, the difference between the two jurisdictions is very minimal: the bare fact of an admission of this sort alone would not be a basis for a prosecution, although a

prosecution could not be ruled out in either country were a further investigation to take place.”

(Chalmers, 2013)

Therefore, the admission of a criminal offence alone in the survey would not be the basis for a prosecution in any part of the UK. Professor Chalmers further pointed out that in Scotland, where transmission does not need to take place for successful prosecution:

“there has only ever been one prosecution in Scotland involving exposure charges, and there has never been a prosecution for exposure *alone*. The published Scottish prosecution policy suggests that prosecutors would be unlikely to pursue exposure charges unless they thought (a) the conduct of the individual concerned was particularly extreme (“a flagrant course of conduct”) or (b) the exposure charges were necessary to help build a case against someone who was being prosecuted for transmission.”

(Chalmers, 2013, emphasis author’s own)

Therefore, it was deemed that the likelihood of a successful prosecution, and the University’s liability, from someone who has knowingly exposed a partner to the HIV virus on the basis of what might have been said in this survey was minimal. It was after this advice that the OUHEC were confident enough to allow me to progress with the survey.

Several other issues were also raised by the committee, but these were primarily methodological rather than ethical in nature. The length and repetitive nature of the survey was of concern to the committee, especially as it took some members over two hours to read. While problems with length were acknowledged, the survey contained a considerable number of branches, which did not appear on the printed version of the survey. Therefore, the committee

received a copy of the survey that listed every single possible survey question. For example, there were two major 'relationship' branches in the survey; one for those who were in a relationship and another for those who were single. No individual could answer questions from both sets of branches. These branches contained several sub-branches to reflect the nature of respondents' relationships and/or sexual lives. Many of these sub-branches contained the same or similar questions that were adjusted according to earlier responses. It was argued therefore that respondents would not face the repetitive nature of questioning encountered by the panel.

The committee also stated that they found the language of the survey 'challenging'. However, a gay man wrote this survey for other MSM and, as far as I was aware, no member of the committee fitted into this category. Much of the language and scenarios, therefore, would be more familiar to MSM and consequently is likely to have impacted on the length of time taken by the committee to read the survey. After this feedback, the survey was tested on a number of heterosexual and male homosexual professionals to gain some insight into the language and the length of time taken to complete the survey. In line with expectations, there was considerable variations in the time taken between the two groups with heterosexuals taking considerably longer to complete the survey. Neither group raised any issue with the language in the survey, although both groups had an awareness of the issues related to MSM's sexual lives. It was decided therefore that heterosexuals would have had more difficulty with the language and terms, which would impact on the time taken to complete the survey.

How to prevent children from accessing this survey was also a concern for the committee. Indeed, this is a problem for all online work of this nature. However, this survey was aimed at men who had sex with men and consequently the link to the survey was unlikely to be accessed by children. For example, I deliberately targeted gay-identifying people on Twitter and Facebook

and snowballed from there by following friends of followers. Nevertheless, I can never say with certainty that this survey did not reach a child at some stage. While there was always a possibility that children may have accessed the survey, Pequegnat et.al. (2007) found that this concern is overemphasised, as far more explicit adult content is more easily accessible on the web. To allay the concerns of the committee, several additional measures were put in place. In the informed consent, the option for respondents to state they were eighteen or over was bolded. In addition, a supplementary age category option (*17 or under*) was included in the age question, which was one of the first questions in the survey. If respondents stated they were 17 or under at this stage of the survey, they were sent to a disqualification page, which stopped them from progressing with the remainder of the survey. Two such respondents were disqualified from the survey as a result of them agreeing to the informed consent, but identifying their age as 17 or under in the age question. While there is no guarantee that a determined child would not be able to re-access the survey, although they could not have done so from the same I.P. address²⁰, it was decided that these actions would minimise the possibility further.

Participants and Recruitment

The target population for this online survey was 500 UK-based men aged eighteen or over, who describe themselves as MSM and are sexually active. The survey ran until the required number of respondents had been obtained from 5th of January until 30th of May 2014. While acknowledging that the term MSM is problematic, the choice of targeting MSM as opposed to 'gay men' was a deliberate choice of the researcher. Connell (1992, 747) stated that 'many men who have sex with men never enter a gay community' and the development of internet relay chat (IRC) has facilitated a growing number of men seeking sex solely online (Mowlabocus,

²⁰ Internet Protocol address. A unique numerical code applied to each device.

2010). In addition, 'if an individual believes that gay men are most at risk of HIV and he does not identify as a gay man, then he may perceive that is at low risk for HIV' (Earnshaw et al., 2012, 575). Those MSM who do not necessarily identify as gay were therefore an important target group as they are the ones least likely to receive the mass media interventions promoted in gay venues and whose opinions may have contributed significantly to this research.

In order to target the correct population, the initial questions of the survey asked respondents if they met this criteria and those who did not were thanked for their time and not be able to proceed with the questionnaire. While people may lie on online surveys, as in other types of research, it was hoped that these initial questions filtered out anyone who was not an appropriate respondent for the research.

The type of online survey used in this research was an unrestricted self-selected survey, which Fricker (2010, 205) describes as 'surveys that are open to the public for anyone to participate in'. A link to the survey was promoted through a variety of online methods, such as websites, on a variety of social network sites, emails to a variety of *interested* groups (such as LGBT societies and relevant listservs), and individuals could choose whether or not they wanted to participate in the survey. Within the university, the survey was promoted on the Faculty of Health and Social Care's (HSE) website and a link was promoted on the noticeboard section of the Open University's website. A similar email was sent to all HSE staff encouraging them to pass the link onto potential respondents.

Men's sex, risk & health survey



Open University PhD student Brian Kavanagh has launched an innovative online survey aimed at men who have sex with men, which examines the issues around sex, risk and health. It is open to all men who have sex with men, who are aged 18 or over and who live in the UK. While it may not be directly relevant to you, Brian would greatly appreciate it if you could disseminate the link to any friends, family or colleagues who could contribute to this research.

Please note, this survey does include language and images which may be deemed explicit in nature. It asks questions about intimate aspects of your sex life and/or relationship. Therefore it is not appropriate to complete this survey in front of minors, people who may be of a sensitive nature and/or partners.

The survey can be found at <https://www.surveymonkey.com/s/OpenMSMSurvey>.

Posted 23.01.2014

Targeting a wide range of MSM through emails and a variety of websites is an attempt to access all potential relevant respondents, achieving 'saturation' and enhancing coverage. This form of targeted recruitment has been identified as the most common and successful form of recruitment used for online surveys (Miller & Sonderlund, 2010). However, it is naïve to suggest that all websites/Twitter accounts had an interest in promoting this study. Many of those who I had previously thought would have an interest in promoting the survey, did not do so when requested. For example, one such organisation who I had asked to promote the survey ran their own LGBT survey a few weeks after I sent a request for them to promote my own. It was therefore not in their interest to promote my survey just before their own. This was also the case for Twitter accounts that facilitated/promoted barebacking or other high-risk behaviours. However, many general tweets with the #BBBH (Bareback Brotherhood) hashtag were utilised and any response elicited through this route would have been especially valuable for the research.

Analysis of Data

Much of the literature on mixed methods points to the 'paradigm wars' between quantitative and qualitative methods and the various challenges researchers face when trying to combine

what was once thought of as ‘antagonist and mutually irreconcilable approaches to the examination of social reality’ (Bryman, 2006, xxvii). Many of these arguments have been dealt with in other sections of this chapter and will become evident again in the forthcoming discussion of both the quantitative and qualitative data analysis. While it is important to acknowledge differences, many of these arguments underestimate the similarities between methods, particularly in relation to analysis. Neuman (2003) draws out four such similarities; they both involve inference, they are a public method, have comparison as a central process and set out to avoid error and misleading conclusions. From this perspective, there is much in common between the two methods and it is these similarities that guided me, as the researcher, through the analysis process.

In the sections that follow, I will outline the approach I took in relation to the quantitative and qualitative analysis by the way of an introduction to how I went about carrying out an integrated analysis.

Quantitative Data Analysis

All the data from the survey, both quantitative and qualitative, were initially downloaded from SurveyMonkey^{®21} into IBM[®] SPSS[®] version 21. SurveyMonkey[®] automatically creates a complete dataset with variable names and coding frame, saving researchers considerable time inputting and coding data. Although changes can be made to the dataset, these variable names and coding frame were kept throughout the analysis. Those respondents who were deemed not to have completed the survey²² were then removed from the dataset and their responses were

²¹ SurveyMonkey Inc., Palo Alto, California, USA. www.surveymonkey.com

²² See ‘Completion Rate’ section of Chapter Five.

not used in any further analysis. A small amount of data manipulation took place to ensure that the data was presented clearly, so the reader would not become overwhelmed with unnecessary data. As Miller et al. (2002, 95) point out, 'no one, no matter how well organised they are or how clear a preconception they have of their analysis plans, can anticipate every eventuality in their analysis'. Therefore, it was necessary to recode some of the quantitative data. For example in the original age variable, a number of options were included that have been recoded. As numbers in the older age categories were too small to make any analysis meaningful, the three separate categories (51-60; 61-70; 71+) were collapsed into one new category (50+).

Univariate analysis was carried out on key variables to gain an understanding of the quantitative responses and summarise the necessary data. As David & Sutton (2004, 269) point out, 'the first stage in the data analysis process is to be able to describe and summarize the single variables in the dataset' through the process of implementing univariate analysis on the data. All the variables used in the univariate analysis are listed in appendix six and the data output produced is presented in the final appendix. The resulting data from this descriptive analysis provided key demographic data about the respondents as a whole and are presented in tables/figure form in the results chapters that follow. While this descriptive data is primarily contained in chapter five, other descriptive data is provided throughout the findings where necessary. For example, results from univariate analysis also appear in chapter six of the findings alongside qualitative data about the emerging risk landscape. Frequency tables for variables were produced and measures of central tendency, such as the median and mode, were also calculated. However, measures of central tendency were only included in the finding chapters when it was considered a necessary addition to the information already supplied. For example, while the mode response for the area where respondents lived was 'city', presenting such information in the findings would not have contributed to the overall argument and was therefore discussed in a more

generalised way. Bivariate analysis of variables was also carried out to establish relationships between variables. During this process, several variables included in the bivariate analysis were also recoded. Contingency tables were used to examine whether relationships existed between variables and are often presented in figure form in the findings chapters. These results revealed some key information about the relationships between the variables. For example, the relationship between 'serosorting' and 'frequency of STI/HIV testing' revealed important information about the testing habits of those who engage in serosorting. Without the use of bivariate analysis, these important details would have been omitted from this research.

Qualitative Data Analysis

While the use of qualitative data analysis packages, such as NVivo®, were considered for this analysis, I opted to use a combination of other analysis options available within the SurveyMonkey® software, and the traditional pen and paper method. Given that I had already used IBM® SPSS® for the analysis of the quantitative data, I was reluctant to embrace a similar package for the analysis of the qualitative research for fear of applying the logic of IBM® SPSS® onto NVivo®, or *visa versa*. However, I did not see the non-use of NVivo® as something that was detrimental to the process of analysis. As Fielding (2002, 176) points out: 'those who use qualitative software testify both that they get ideas from working with the software and that they get ideas in traditional ways...using software won't prevent the 'eureka' effect, but it won't guarantee it either'. Nevertheless, I was also aware of the practicalities of analysing up to 557 qualitative responses without the assistance of any software. Therefore, the SurveyMonkey® software was employed to apply the initial open codes, which was used to guide further analysis²³. While this SurveyMonkey® analysis function is a relatively new addition to their

²³ A full list of the qualitative codes used in the analysis are listed in appendix five.

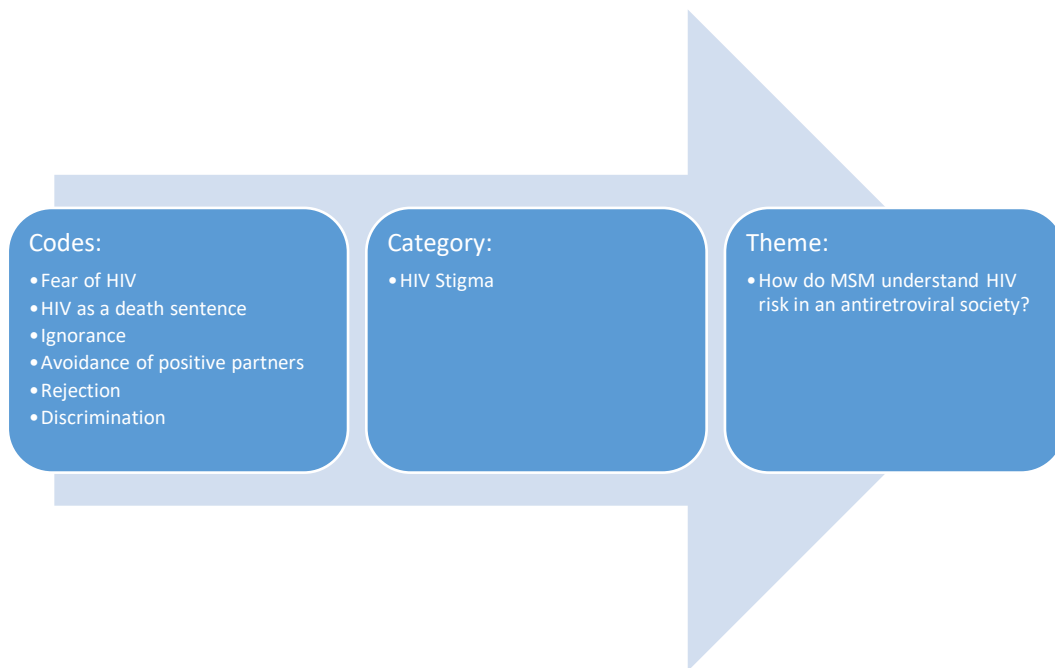
already established software, Callegaro et al. (2015) predict that this type of analysis will become increasingly integrated in the future. Codes were chosen and colour coded to allow for easier analysis. These codes emerged from the content of the responses to each individual qualitative question and driven by the repetition of certain key themes within each set of responses. Given the number of responses, it was not uncommon for newer themes to emerge as I progressed through the data and/or earlier themes were re-examined in the light of the newer data. Where necessary, more than one code was applied to a response to reflect the complexity of some responses.

While these themes from individual questions revealed a wide number of codes, the constant comparative method was used to reveal several key categories related to the initial codes. This method, that lies at the heart of qualitative analysis, is one in which the researcher constantly compares and contrasts the data as a means of refining the provisional coding frame (Barbour, 2008). It was during this axial coding, that it became evident that several core categories ran through, and were intertwined within, all sections of the findings. For example, themes such as 'HIV disclosure', 'HIV stigma' and 'othering' became key categories in the axial coding stage that overlapped and influenced many different aspects of this research. It was in this process that these new codes and ultimately, the story that informs this research, began to emerge.

For example, the figure below indicates how I moved from a collection of codes that emerged from the qualitative data, through to a category, in this case, HIV stigma and how that category related to one of the key themes in this research. While this figure indicates a relatively straightforward process, this was not always the case. Two of the key codes listed in the figure, rejection and discrimination, played a key role in the creation of another separate category, the process of othering, a category that is also related to the same theme. In addition, the category

HIV stigma also related to other categories, such as the process of othering and disclosure. The complexity of this process for all the qualitative codes, categories and themes that emerged from the research are listed in a colour-coded appendix five at the end of this thesis.

Figure 4.1: Relationship between Codes, Category and Theme: An Example



At this stage, the final process of selective coding began, which Fielding (2001, 248) describes as involving the researcher 'scanning both the codes and the data and then selecting cases to illustrate major themes uncovered'. This process involved the reorganisation of earlier coding to reflect the new structure that emerged from axial coding. It allowed for the re-organisation of earlier themes and an elaboration of the major themes. This selective coding informed the structure of the findings chapters and the discussion.

As mentioned earlier, the initial stage of data analysis was carried out through the lens of the topics that derived from the literature, namely risk understanding, masculinities and risk, relationships, risk and negotiation and the negotiation of sex. Therefore, the open coding stage

was driven by a thematic analysis of the qualitative data. The approach taken in this thematic analysis is largely congruent with the grounded theory approach to data analysis, but within a broadly social constructionist approach. While this method of analysis encompasses two approaches, Barbour (2008, 234) points out that she is:

‘always suspicious of any qualitative report of paper where the data are purported to fit neatly into any theoretical framework. Experience suggests that real life – and systematic and thorough qualitative data analysis – is much more complex.’

Bryman (2012, 580) points out in his discussion of thematic analysis that placing ‘an emphasis on repetition is probably one of the most common criteria for establishing that a pattern within the data warrants being considered a theme...[which] must be relevant to the research questions or research focus’.

Integrating analysis of qualitative and quantitative data reflects the complexity, identifying instances where there is a fit between two types of data, but acknowledging and drawing on as a resource, those places where contradictions or qualifications arise.

[Integrating Analysis of Quantitative and Qualitative Data](#)

As discussed above, the initial analysis was guided by the four key themes that derived from the literature. While the analysis of both quantitative and qualitative data was carried out separately, the findings were examined together. Here, I have been guided by Greene’s (2007, 144, emphasis author’s own) understanding of the component design in mixed methods research:

‘Mixed methods analysis for component designs proceeds more or less *independently* for each method or set of methods, following the procedures of each methodological tradition. Then the mixing or linking or connecting happens at the inquiry stage of interpretation and inferencing.’

Therefore, while both the quantitative and qualitative data from the survey were analysed independently of one another, they were merged and integrated at the interpretation stage to gain greater insight into the responses. The statistics garnered from the quantitative data analysis revealed patterns within the dataset to which the qualitative data furnished explanations for these patterns. For example, question 101 on the survey asked respondents to choose from several potential aspects of their relationship agreement. This quantitative data revealed a pattern of the types of aspects that respondents included in their relationship agreements. It was evident from the responses that a theme of intimacy ran through many of these responses. Subsequent analysis of the qualitative data confirmed the importance of intimacy to men in open relationships, thereby supporting the original result found in the quantitative data. However, the quantitative data also shed light on the responses that emerged from the qualitative responses. These results often provided a context and some essential information about the respondent themselves, which revealed more about the qualitative responses. For example, many respondents expressed moral opinions about those they believed were putting themselves at risk of HIV acquisition. However, the quantitative data revealed that many such respondents had also previously engaged in behaviour not dissimilar from those they made moral judgements about. Therefore, the integration of both the qualitative and quantitative data provided rich, textured results about both sets of data that was unlikely to have emerged otherwise. In such cases, both sets of data fed into one another in ways that was not intended nor expected and became a strong point of this analysis. Such divergent findings became one of the primary benefits of using mixed methods in this research and serve to justify the use of this method for the research:

‘Not only [does divergence] enhance the robustness of the study, it may lead to different conclusions from those that would have been drawn through relying on one method alone and demonstrates the value of collecting both types of data within a single study. More widespread use of mixed methods in trials of complex interventions is likely to enhance the overall quality of the evidence base.’

(Moffatt et al., 2006, 28)

While each individual method may have produced similar data, the combination of both methods enabled the production of more nuanced stories revealing the complexity of respondents’ experiences and thinking.

These emerging themes within the qualitative data were also examined alongside relevant quantitative data to understand what information was evolving about each of the topics that had earlier emerged from the literature. At times, in order to obtain an understanding of any trends that were emerging within categories of responses (e.g., if there was a notable trend within the responses of younger *vis-à-vis* older respondents). This combination of the quantitative and qualitative data began to reveal various core themes that related to the themes that derived from the literature. This stage was repeated for each of the themes from the literature, before all the data was collated.

In the coming chapters, the qualitative and quantitative data are not treated separately, but examined together. Each informs the other revealing the contradictions that are often present in what respondents say and what they actually do. However, it is often the case in mixed methods that one method may take priority over the other:

‘Although we do not consider relative weighting a defining feature of mixed methods designs, determining the priority of study components remains a consideration in the development of a data analysis plan.’

(Curry & Nunez-Smith, 2015, 232)

While such a priority may be decided prior to the beginning of the research, or at any stage of the data analysis, the priority of the qualitative data for this research emerged during the axial coding stage of data analysis, in which certain key themes such as HIV stigma and othering emerged. This does not mean that the quantitative data did not play an important role in the research. Indeed, it has a crucial supplemental role in the construction of the story that emerges from the research. However, in what follows, the results are presented more as a story that has been guided by the qualitative research, rather than a statistical-led quantitative report. Therefore, it is the integration of the data that informs both the research story and the construction of the findings chapters that follow. While each piece of research could stand alone on its own merits, it is only in combination of the data that a newer, more nuanced story unravels.

Reflexivity

Like all researchers, those who employ the online method bring their own subjective views on topics to the research setting. Thankfully, two eagle-eyed supervisors helped in encouraging me to reflect on certain lines of questioning to ensure greater objectivity. Nevertheless, there are certain factors that I inevitably brought to the research and the approach to analysis. Whilst my age means that I am between the younger and older age groups, my ability to relate to younger aged groups may have been impaired. For example, a number of younger respondents

commented upon the dated nature of the images used for the comparison of men in appendix three. The phrasing of these responses certainly made me aware of my own age and reminded me that I am probably 'too old' from the perspective of some younger respondents.

As discussed in the rationale for this research, I came out in Ireland in the early 1990s at a time when homosexuality was still illegal. This means that I was, whether I wanted to be or not, forced to be a transgressor. Therefore, my story of coming out is probably aligned much more closely to someone who came out during the early 1960s in the UK. Of course, as the equal marriage referendum in Ireland attests, laws on homosexuality between the two countries have become more closely aligned. However, during the process of this research, I came to realise that my own positioning on transgression was unlikely to be the same as a MSM of my own age in the UK and that I was more transgressive than I previously thought. While I prefer not to think that I have aged thirty years during this research, although sometimes it has felt like it, these differences between Ireland and the UK will undoubtedly have impacted on my approach to this research.

Much thought and consideration was given to my own serostatus and the impact this could have on the research questioning and subsequent analysis of data. For me as a researcher, this was a difficult balance to find. Inevitably, each serostatus gives a researcher an advantage to see the world from particular viewpoint. However, serostatus can also create a disadvantage in that it may not allow you see beyond this perspective. For example, it could be argued that a seropositive researcher comes to the research after a 'biographical reinforcement' (Carricaburu & Pierret, 2002) as a result of seroconversion and therefore may have a different view of sexual risk-taking compared to a seronegative researcher. Equally, seronegative researchers can be challenged as they have not gone through the process of seroconversion and are, therefore,

unlikely to fully understand the perspective of seropositive men. As such, it can be argued that the serostatus of a researcher is both an advantage and a hindrance in this type of research. Therefore, the researcher's serostatus inevitably impacts on the research. However, awareness of how serostatus can affect the research process is key to minimise any impact it may have on the research.

Conclusions

This chapter set out the methodological approach taken in this survey, which contained a variety of closed, open, attitudinal and vignette questioning. The integration of both qualitative and quantitative questioning in the survey allowed large-scale nuanced data to be collected from the survey. The online method provided a series of advantages for this sensitive research that make it preferable to other methods, most notably the traditional survey. Online surveys have proven successful at reaching difficult-to-access groups from wide geographical areas in a short timeframe, allowing for national coverage and providing a snapshot of what was happening within the group at a particular time (Wright, 2005). This proved particularly important for this research as the more recent developments in the field of HIV, such as home testing kits and PrEP, could be integrated into the survey to ensure that the most current understanding of HIV emerged from the results. Internet surveys also had the advantage of reassuring respondents of their anonymity reducing the likelihood of socially desired responses (Wang et al., 2005). While there were a few drawbacks to the use of the online method, the numerous advantages made its use more beneficial than other research methods.

The potential for respondent dropout was overcome using recent technological advances that provided particular design techniques not available in traditional surveys, thereby minimising

the possibility of respondent confusion (Kypri et al., 2004). There was a concern that if respondents could not be kept engaged with the survey, dropout rates would be high. Therefore, several techniques were employed to minimise any confusion respondents may have encountered, such as filter questions, automated branching, automatic skips and tailored questioning (Wright, 2005). Given the sensitive nature of some of the questioning in the survey, consideration was given to the number and location of such questions in the survey. Visual materials were also used to provide stimuli for respondents while progressing with the survey and vignettes were used to facilitate comparison (Bryman, 2012). Such materials were specifically created and integrated into the survey to maintain respondents' interest and allow for nuanced understandings of responses to emerge. These included the use of a variety of mass media interventions, self-generated mock profiles and vignette questioning. However, much attention was paid to these materials to ensure that the image and/or content were familiar to respondents. Therefore, the piloting of this survey was particularly important and raised a number of key issues that were addressed prior to the launch of the survey. While constructing an online survey to maintain respondents' interest was a challenge, the various stylistic features provided by the online method meant that these various formats could be integrated into the survey to ensure the highest completion rate could be obtained.

The discussion of ethics raised important points about sensitivity, respondent confidentiality and anonymity (Sue and Ritter, 2007) in addition to the challenges presented by the Open University Human Ethics Committee in relation to this research. This included concerns about the length and repetitive nature of the printed survey and apprehensions about the impact of HIV transmission laws on the research. Several steps were taken to minimise these concerns, which included seeking legal advice on the HIV transmission laws (Chalmers, 2013) and adding an 'other' as an option in some questions, while also robustly defending the collection of

demographic data and my arguments about not including warnings in front of questions in order to avoid another ethical issue of distress.

The analysis of the data section addressed the philosophical arguments against the use of mixed method (Bryman, 2006) while discussing the analysis of the quantitative and qualitative data that emerged from the survey. The quantitative analysis section specified the approach to the analysis of the quantitative data (David & Sutton, 2004), including details about recoding and the univariate and bivariate analysis carried out on this data. The qualitative data analysis section sheds light on the thematic analysis and how the initial codes that emerges from the responses were related to the categories and ultimately how they connected to the themes that derived from the literature (Barbour, 2008; Fielding, 2001). How the qualitative and quantitative analysis was integrated was the subject of the final part of the analysis section of this chapter (Greene, 2007; Moffatt et al., 2006). It was in this process that much of the rich, textured data from a very large number of respondents began to emerge. The combination of both quantitative and qualitative data in this research allowed for the collection of rich, textured data from a large number of people over a very short period of time, which became a strong justification for the use of mixed methods in this research.

The final section of the chapter discussed the possible impact that I, as a researcher, could have brought to this work. However, awareness of these issues goes some way to limit their impacts.

Chapter Five – Respondent Background and Attitudes to Relationships

‘I take safe sex and monogamy very seriously, although I have on occasion engaged in bareback sex with partners, not random strangers.’

(R20, aged 25-30)

Introduction

This chapter will provide some of the essential background details about the completion rate and the background of respondents. Issues such as age, location, sexual identity, alcohol and drug consumption, serostatus, HIV testing, and relationship understanding will be discussed and will provide an overview of the respondents to the survey. These findings will also inform discussions in subsequent chapters. Much of this information emanates from the quantitative data in the survey, although more qualitative data is integrated in the discussion of respondents' understanding of relationships. This qualitative data provides an insight into the complexity of relationship construction in the MSM communities and raises concerns about the possibility of HIV transmission within such relationships.

Completion Rate

In total, 937 respondents began the survey by stating that they had read and understood the relevant information contained in the informed consent. However, 80 respondents were unable to/did not wish to agree with the eligibility questions for the survey. It is possible that, as Twitter has an international reach, people clicked the link to the survey without fully understanding it was only open to those who lived in the UK. Therefore, these respondents were ineligible to participate in the remainder of the survey. A further two respondents had confirmed that they were over the age of seventeen in the eligibility questions of the informed consent, yet stated that they were aged seventeen or under in the age question. These respondents were disqualified from the survey on the basis that they did not reach the requirements for survey respondents.

Therefore, there was a total of 855 valid respondents to the survey. Of these, 557 respondents were deemed to have completed the survey, making a completion rate of 65%. For the purposes of this research, completion was defined as the respondent answering the final compulsory closed question of the survey. While this completion rate did not reach the 70% achieved by Evans et al. (2004), it remained significantly higher than other internet surveys (Sills & Song, 2002). However, considering the time commitment (20-30minutes) and the sensitive nature of some of the questions in the survey, I was satisfied with the response rate achieved.

While most questions in this survey were not compulsory, missing data was not a significant issue in the dataset, possibly because of the inclusion of responses such as 'rather not say', 'other' and open text boxes for respondents to provide more detail and/or to list other responses not included in stated options. For example, when respondents were asked to explain why they test for HIV at the frequency they had stated, the quantitative results show 31 missing responses. However, further analysis of the qualitative responses indicated that 37 respondents had opted to provide a qualitative response to this question. Therefore, there was no missing data for this question and six respondents provided additional qualitative information, even though they were not required to do so. Low levels of missing data were found throughout the survey indicating that the vast majority of respondents answered questions, even those that were considered to be the most sensitive in nature. For example, while concern was raised by the OUHEC about the sensitive nature of questions in the survey, the question about respondents' engagement in barebacking elicited a response rate of over 99%, while income had a slightly lower rate of 94.4%. The low percentage of missing data for such questions suggests that respondents might be more willing to provide sensitive information of a sexual nature in online surveys than previously thought.

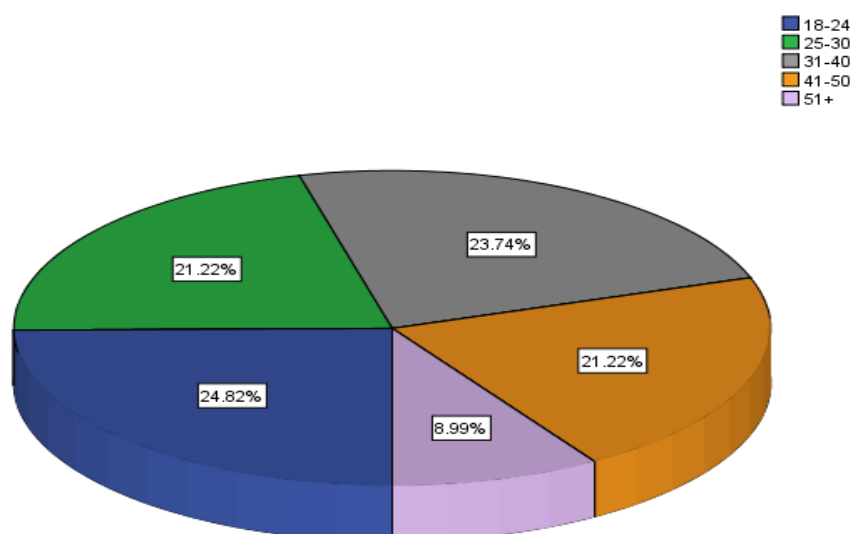
Responses to qualitative questions varied throughout the survey. As discussed, many qualitative questions were only necessary for respondents who opted to contribute additional information about their quantitative responses. However, other questions were more directed and respondents were asked to contribute information based on an individual unrelated qualitative question. For example, of the 311 respondents who could answer the question about why they would not consider having sex with someone who was seropositive, only 273 provided a qualitative response, suggesting a response rate of 87.8%. However, given the challenging nature of this question, it was perhaps unsurprising that 38 respondents chose not to respond. In addition, the amount of detail provided in qualitative responses varied greatly. While some respondents provided one-word responses to qualitative questions, others provided lengthy, detailed answers. This did not mean that those one-word responses did not provide quality information. At times, many of these responses contained strongly held beliefs and sentiments. For example, many seropositive respondents used one-worded responses in answer to the question about whether or not they believed it should not be compulsory to state serostatus on profiles (e.g. 'stigma!'). These types of responses often expressed as much detail as the more lengthier answers provided by respondents.

Respondent Background

I. Age

As with other internet surveys, more people in younger age groups completed the survey than older groups. Less than ten percent of respondents (8.9%, N: 50) were aged 50 years or over, with the median age group of respondents being 41-50 years. However, there was almost equal representation of respondents in the other age groupings, with 24.8% (N: 138) aged 18-24, 21.2% (N: 118) aged 25-30, 23.7% (N: 132) aged 31-40 and 21.2% (N: 118) aged 41-50. This distribution is represented in the pie chart below.

Figure 5.1: Age of Respondents



II. Location

The vast majority of respondents to this survey lived in England (83.7%, N: 463), with smaller percentages from each of the other countries of the United Kingdom. These percentages were largely in line with the percentage population of the 2011 census of the United Kingdom. Only one respondent hailed from the British Crown Dependencies. Just over half the respondents were city dwellers (54%, N: 301), while a further 34% (N: 191) lived in a town. Only 11% (N: 62) of respondents stated that they lived in a village or rural location. Of those who lived in a city or town, a significant number of these (47.1%, N: 226) hailed from locations outside the twelve main cities listed in question five of the survey²⁴. The only significant representation came from London, which accounted for 15.4% (N: 85) of respondents.

²⁴ The cities were chosen based on population, capital cities and urban centres with large MSM communities.

The vast majority of respondents (90.1%, N: 502) were born in the United Kingdom. The remainder of respondents hailed from a large variety of countries, with the largest representations from countries such as Australia, (Republic of) Ireland²⁵, Canada, USA, Germany etc. Only eight respondents hailed from the continent of Africa (1.4%), where HIV rates are higher than in other continents. The vast majority of respondents also identified themselves as being from white backgrounds, 87.5% (N: 485) of whom identified as white British, with a further 7.8% (N: 43) from other white backgrounds. The remaining 4.7% of respondents (N: 26) came from a variety of backgrounds. While every effort was made to attract people from all ethnicities, the survey failed to reflect this desired variation.

III. Sexual Identity

When questioned about sexual identity, the vast majority of respondents (89.3%, N: 494) stated they were attracted to men only, with a further 8.7% (N: 48) stating they were attracted mostly to men, but sometimes to women. However, over ninety percent of respondents (92.9%, N: 514) used the term 'gay/homosexual' to describe their sexual identity. Interestingly, those who stated that they were 'mostly attracted to men and sometimes to women' were more likely to identify as 'gay/homosexual' (58.3%, N: 28) than other terms (41.6%, N: 20). This suggests that men in the UK were more likely to embrace the term 'gay/homosexual', even though they might also be attracted to women.

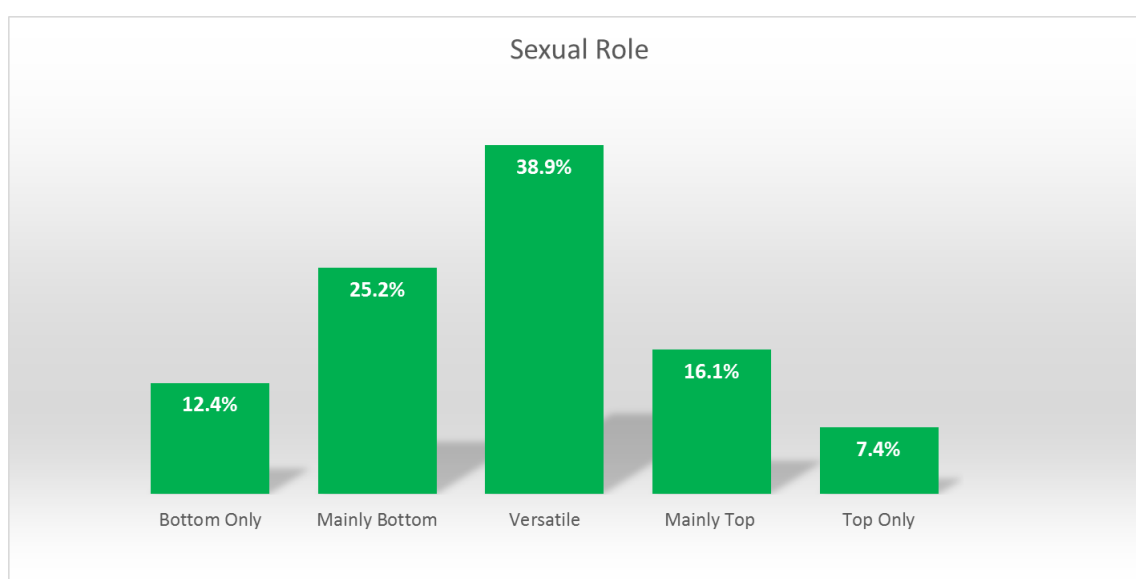
IV. Sexual Role

Respondents to the survey were also asked to identify their sexual role. This was important for this research, as sexual role impacts on the risk of HIV acquisition, with those identifying as bottom/receptive-only considered to be at greatest risk. The results indicated that only 12.4%

²⁵ Respondents used a mixture of 'Ireland' and 'Republic of Ireland' in their responses to this question. However, as this question was only asked to those who stated that they were born outside the UK, we can presume that all respondents meant the 'Republic of Ireland' in their response to this question.

(N: 67) of respondents identified as bottom-only, with almost twice as many respondents (25.2%, N: 136) characterising themselves as mainly-bottom. By far, the greatest number of respondents identified as versatile (38.9%, N: 210), suggesting that they were able to take either role in sex. Smaller numbers were contained in the active categories, with 16.1% (N: 87) identifying as mainly-top and a further 7.4% (N: 40) being top-only. These results are presented in the bar chart below.

Figure 5.2: Sexual Role of Respondents



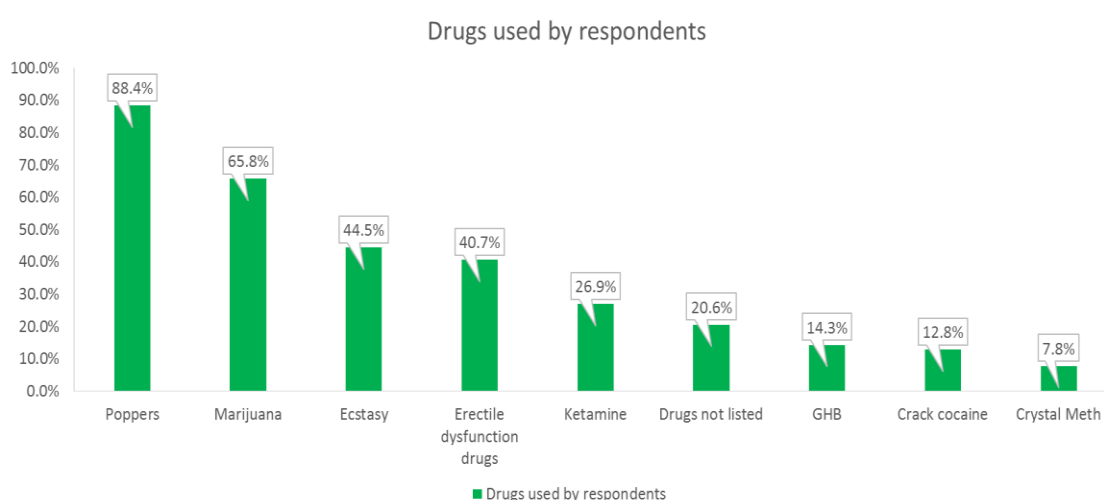
However, sexual role identification is not absolute and can vary between sexual activities. For example, while one might be mainly-bottom in oral sex, the same person might also be top-only during anal sex. Nevertheless, these terms are commonly used as identifiers on MSM websites, where they are usually taken as indicators of position preferences for anal sex.

V. Alcohol and/or drug consumption

The vast majority of respondents to the survey considered themselves to be light (40.5%, N: 211) or moderate drinkers (44.7%, N: 233), with less than fifteen percent (14.8%, N: 77) identifying as heavy drinkers. Over seventy percent of respondents (71.8%, N: 400) specified that they had used drugs at some stage in their lives, with the most commonly-used drugs being poppers

(88.4%, N: 352), marijuana (65.8%, N: 262) and ecstasy (44.5%, N: 177). The fourth most commonly used drugs were erectile dysfunction drugs (Viagra, Kamagra, Cialias, Levitra) with 40.7% (N: 162) of drug-using respondents taking such drugs. However, as these drugs can be prescribed to men for medical purposes, this figure may be called into question. Given the high coverage in the MSM media about crystal meth usage, only 7.8% (N: 31) of respondents reported having used this drug, which was the least-commonly used drug among respondents to this survey.

Figure 5.3: Respondents' drug usage



However, drugs were not often used in isolation. For example, 85.6% (N: 339) of those who had used drugs admitted that they had done so with alcohol and just over half (50.9%, N: 178) had used them in combination with other drugs. As a result, these respondents were less likely to be in control of their decisions and their ability to negotiate safer sex. A significant minority of respondents (46.2%, N: 183) felt that their decision-making capabilities changed when under the influence of alcohol/drugs. A further 26.5% (N: 105) had neutral opinions, while only 27.3% (N: 108) disagreed. This suggests that only just over a quarter of respondents who had taken drugs felt they were in full control of their decision-making capabilities while they were high.

VI. Serostatus and HIV testing

Just under ten percent of respondents to this survey (9.9%, N: 55) identified as seropositive, with a further 70% (N: 390) stating that their last test was seronegative. However, even if their test was negative, this was not a definitive indicator of serostatus. There was a possibility of seroconversion since their last test, that they misunderstood the window period in HIV testing and/or that they did not wish to disclose such sensitive information. Eighty-eight respondents (15.8%) had never been tested for HIV or any STI. In addition, 4.3% of those who had been tested for STIs (N: 24) had never received a HIV result. This may have been caused by the respondents not being offered, or refusing, a HIV test, or that they had tested, but had yet to receive their result. However, there may be the possibility that some of these men who attended clinics might be 'slipping under the radar' by not receiving HIV tests/results.

Over two thirds of respondents (67%, N: 313) stated they test for HIV/STIs at least once a year, which is the recommended testing cycle for men who have not engaged in risky sex. Just over a quarter of respondents (27.2%, N: 127) tested at least once every six months with a further 12% (N: 56) being tested once every three months. However, just under one third of those who stated that they had tested once every three months (32.1%, N: 18) were seropositive, suggesting that this was a requirement of their treatment. While these results indicated that there was considerable regular HIV testing within the MSM communities, the remaining one-third of respondents (N: 153) were testing less frequently than the recommended once a year. Further analysis of these results indicated that over seventy percent (71.2%, N: 109) of those who were testing less frequently had previously engaged in bareback sex with someone other than a current relationship partner (CRP). This indicates that if respondents had engaged in the last year, they may have been doing so without full knowledge of their current serostatus.

Respondents' attitudes to relationships

When asked how they would describe their relationship status, 37.5% (N: 209) of respondents who stated that they were single, 45.6% (N: 254) stated that they were in some form of a committed relationship with another man, while a further 14.5% (N: 81) stated that they were dating. It was left to each individual respondent to define 'committed relationship' and 'dating'. For example, 22.2% (N: 18) of respondents who stated they were 'dating' were doing so for at least three years, but did not define themselves as being in a 'committed relationship'. Seven respondents (1.3%) refused to answer this question, while a further six (1.1%) were married to a woman.

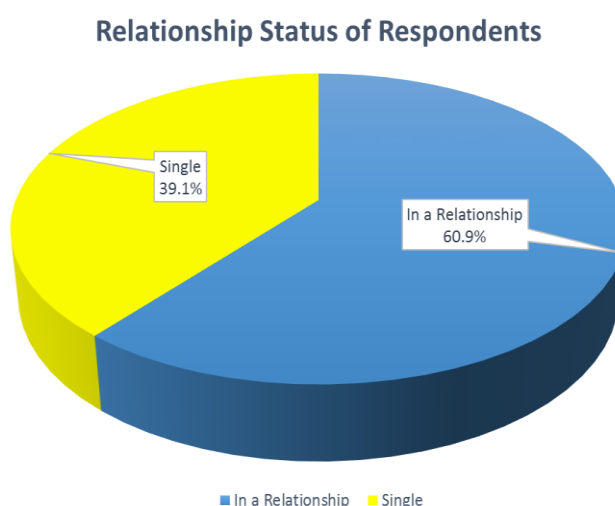
While same sex marriage was introduced during the latter stages of data collection (first marriage permitted on 29th of March 2014), the 2.5% (N: 14) of respondents who stated that they were married to a man might have been married in another country where it was legal for a longer period of time. However, during the lead up to the legalisation of marriage in the UK, it became increasingly common for men in the communities to refer to their partner as their 'husb*'²⁶. Indeed, when men in relationships were asked to choose a term for their partner to filter subsequent questions, 11.6% (N: 39) opted for the term husband. Therefore, it is possible that some respondents considered themselves to be married, even though they were in a civil partnership and/or a committed relationship.

For the purpose of analysis, those respondents who stated they were in a 'civil partnership or committed relationship', were 'married to a man' or were 'currently dating' were combined into

²⁶ Husb*: alongside the traditional term 'husband', other terms emerged such as husbro, husbear etc.

one category and will be hence referred to as being 'in a relationship' (60.1%, N: 335). Those respondents who stated they were 'married to a woman' were combined with those who identified as 'single', in order to avoid confusion between primary/secondary partners of those married to women (38.6%, N: 215). The seven respondents who opted for the 'rather not say' option were excluded from any further analysis relating to relationships. The final breakdown of relationship status in the survey is represented in the graph below.

Figure 5.4: Relationship Status of Respondents (adjusted)



I. Opinions about 'monogamy'

All respondents, both single and those in relationships, were asked to give their opinions about monogamy in general, prior to giving detail about their own experiences. It was felt that single respondents could give opinions about monogamy, as they were likely to have some experience of monogamy and/or questioned whether it was a suitable option for them. Over three-quarters of all respondents (78.4%, N: 402) held primarily positive views of monogamy²⁷. Further analysis

²⁷ Respondents were asked to state if, overall, monogamy was 'something they are wholly committed to', 'an ideal to which they aspire', 'an uncomfortable pretence' or 'an unnecessary constraint'. An open text box was also included for other options. For the purpose of this analysis, those who held positive views of monogamy were those who felt that monogamy was 'something they were wholly committed to' or 'an ideal to which they aspire'.

of these figures revealed little difference between those in relationships (77.7%, N: 238) and those who were single (80.1%, N: 161), and between those who were satisfied (80.9%, N: 207) and those who were dissatisfied with their sex lives (76.7%, N: 125). Therefore, I can conclude that the vast majority of respondents held primarily positive views of monogamy.

However, opinions about what monogamy meant to respondents varied in the survey. While the vast majority of respondents thought that having any form of oral or anal sex (active or receptive) with another man was a breach of monogamy, 19.5% (N: 106) felt their views of monogamy would change if their partner lived away from home/abroad and 11.2% (N: 61) felt it would change if the sex happened in an anonymous setting (e.g. darkrooms, gloryholes etc.). However, variation in the definition of monogamy was not solely dependent on the location of the sex and/or the partner. For example, 15.3% (N: 13) of those who stated that monogamy 'was something they were wholly committed to' were in open relationships. This suggests that, for these respondents, having an open relationship did not constitute a breach of monogamy, perhaps based on a separation of sex from other emotions, such as love, intimacy and commitment. In the quote that follows, a single respondent differentiated between monogamy and sex, which he saw as being separable:

'Monogamy is something that doesn't have to be focused on sex. Monogamy can be your relationship outside the bedroom.'

(R77, aged 31-40)

While many saw the definition of monogamy as something that was stable or fixed, others felt it involved something more fluid. R142, who was in an open relationship, stated that he liked the idea of being monogamous 'on the whole', but also enjoyed having sex with other men on occasion. For him, monogamy was not about all or nothing, it was flexible to accommodate his needs:

‘I like being monogamous on the whole, but like to play once or twice a month elsewhere’

(R142, aged 31-40)

R24 gave more detail about what he referred to as his ‘monogamish’ relationship, in which he and his partner had sex with other men while remaining committed to one another. In this way, he avoided the ‘constraining’ aspect of monogamy, while keeping certain sexual activities exclusive to the primary relationship. In this way, he could keep most of the more intimate acts between himself and his primary partner, while they remained ‘in the game’ and limited the amount of ‘risk’ they exposed themselves to. However, it was unclear from this response if the risk the respondent discussed was in relation to the maintenance of the primary relationship or to sexual risk:

‘My partner and I are ‘monogamish’, which means we have sex with other guys together...in the context of threesomes or foursomes. We have a strict rule that we do not allow anal sex with other guys – we like to keep that more intimate act for us. When we do engage in sex with other guys, the activities are limited to kissing, wanking and sucking...this still let’s [sic] us feel we are ‘in the game’, and we can meet our needs for sexual exploration and variation...as well as limiting the amount of risk we put ourselves at.’

(R24, aged 31-40)

For others, monogamy was viewed as taken-for-granted ‘norm’ in society and something that they felt the need to challenge. It was usual in these contexts to speak in terms of honesty and trust between partners, something they felt was aided by being open about their sexual needs in comparison to the deceit many saw in other ‘monogamous’ relationships. As R23, a man in an open relationship, pointed out:

‘If monogamy is based on ‘that’s what society tells me is the right way to do things’, but there is no communication/discussion around genuine needs and desires on both sides, then it could well be the cause of many problems.’

(R23, aged 41-50)

R344, a single respondent, made a comparison between different human desires and questioned if denying a partner the opportunity for sex was the same as denying him food if he was hungry. Once again, honesty and trust, which he saw as inherent in open relationships, were cited to justify why open relationships were preferable to monogamous ones:

‘...Also, given the wide variation in sexual appetites, there will usually be a mismatch in how much sexual activity partners require. It wouldn’t be fair to insist that your partner didn’t eat when you weren’t hungry, and it seems to be sex is a desire as strong as hunger. Amongst the most important aspects of a relationship are trust and honesty. Many men struggle with monogamy and in an effort to maintain the pretence resort to lying. This is far more damaging than the act of having sex with someone else.’

(R344, aged 41-50)

However, in as the following discussion reveals, deceit is equally common in both monogamous and open relationships (+/-2%). Given that much of the discussion on open relationships was based upon notions of honesty and trust *vis-à-vis* monogamous relationships, these arguments were considerably weakened by the evidence of actual practice reflected in other parts of the survey.

II. Men in 'monogamous' relationships

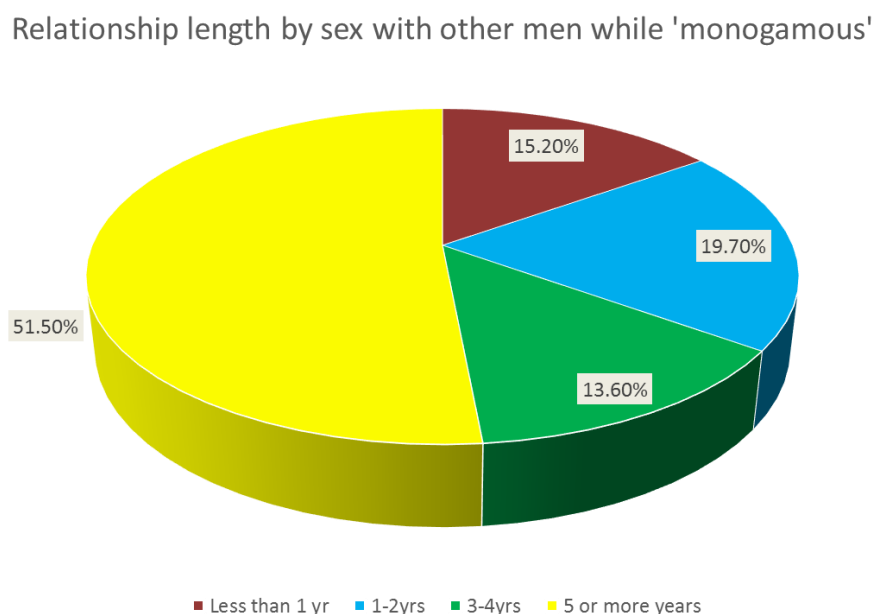
Given the challenge of defining monogamy, respondents in relationships were asked if they had made an agreement with their partner that allowed them to have sex with another man/men. It was thought that such a question would avoid the complexity of trying to define monogamy for respondents. Just over three in every ten respondents in relationships had made such an agreement (31.2%, N: 103), while the remainder (68.8%, N: 227) had not. These two hundred and twenty seven respondents will be hence referred to as those in monogamous relationships and will be the subject of this section of the chapter. Those who made such agreements, henceforth referred to as those in open relationships, will be dealt with separately.

Half of those in monogamous relationships specified that they had difficulty remaining monogamous, although only eight percent (N: 18) stated that they 'often' found it difficult. While just over ten percent of respondents (10.7%, N: 24) were aware that their partner had sex with another man while in a 'monogamous' relationship, a further 13.3% (N: 30) expressed some uncertainty about whether or not their partner had engaged in sex with another man. This indicates that almost one quarter of men in monogamous relationships either knew about or were unsure whether their partner had sex with another man during periods of monogamy in their relationship.

Just over three in ten men in 'monogamous' relationships (30.2%, N: 67) had sex with another man during periods of monogamy, while a similar percentage of men in open relationships (28.2%, N: 24) admitted that they had not kept within the limitations of their relationship agreement. Further analysis shows that, if a 'monogamous' respondent was confident that his partner had been faithful, he was far less likely to have had sex outside the relationship (23.7%, N: 40) than those who knew, or were unsure if, their partner was unfaithful (47.8%, N: 11). The results also indicated that those in 'monogamous' relationships of five years or longer were

more than twice as likely to have had sex with another man as those in shorter relationship lengths. Just over half of those who had sex with another man during their relationship were in longstanding 'monogamous' relationships (51.5%, N: 66). This might be because these respondents have had more opportunity to have sex with others than those in shorter relationships. However, given the sharp rise between those in shorter and those in longer relationships, there was likely that there was another explanation for this.

Figure 5.5: Relationship length by sex with other men while 'monogamous'



Respondents also felt that there would be clear consequences for them if their partner found out that they had sex with others during periods of monogamy. Around two thirds (66.2%, N: 45) felt that, if partners found out, it would lead to the end of their relationship; while 19.1% (N: 13) felt that their partner would understand, or that it would not concern him. However, just over one in ten respondents in 'monogamous' relationships who had sex with other men (10.3%, N: 7) had told their partners that they had sex with another man and were still together at the time of the survey. This suggests that those who were in monogamous relationships and had sex with other men were mindful of the consequences if their partner became aware of their

deceit, with the majority of them believing that it would lead to the dissolution of their relationship. Therefore, if they wished to remain in a relationship with their primary partner, they had clear reasons for not informing him about their indiscretion. However, in remaining silent about their indiscretion, these respondents could also potentially expose their primary partner to HIV and/or other STIs.

III. Men in open relationships

As previously discussed, 31.2% of respondents in a relationship (N: 103) had made an agreement with their partner to have sex with other men, henceforth referred to as those in open relationships. Almost three out of five respondents (59%, N: 59) felt that opening their relationships had not affected their primary relationship, suggesting that these men were confident in maintaining their primary relationship while also having sex with other men. Almost three-quarters of respondents in open relationships (71.6%, N: 73) felt that they had equal input in establishing the open relationship and almost half (49%, N: 49) had reviewed their agreements a number of times. This indicates that men who open their relationships reviewed their agreements and felt they had equal input into these discussions. However, a quarter of respondents in open relationships (25%, N: 25) had never reviewed their agreement, even though it had been made some time ago²⁸. When an agreement had been made, respondents were likely to have acted upon the agreement with only 17.5% (N: 18) of respondents in open relationships not acting upon their agreement. However, further analysis of these figures revealed that four of these respondents had only made their agreement recently and it is, therefore, possible that they will act upon it in the future.

²⁸ An option was provided for respondents who had recently made an agreement. It was up to each individual respondent to define what they meant as 'recent'. The 25% mentioned does not include those who have made their agreement 'recently'.

Respondents to the survey were given a variety of arrangements and asked to state if these were an element of their relationship agreement. However, it is important to note that respondents may have believed that these were part of their relationship agreement without having held a detailed discussion with their primary partner. Nevertheless, the results revealed some interesting facts about what was covered in relationship agreements. A 'none of the above' option was also given for respondents who did not see any of the arrangements to their agreement on the list provided. This did not mean that these respondents did not have any arrangements, but rather that their arrangements were not listed in the options provided. The results are listed in the table below:

Table 5.1: Type of arrangement within relationship agreements

Type of arrangement	Percentage Response	Number Response
Don't sleep over	32%	31
Only have threesomes in company of your partner	28.9%	28
Never have sex with an ex	22.7%	22
Never have sex with friends	22.7%	22
Don't have sex in our home/s	21.6%	21
Don't share contact details afterwards	17.5%	17
Never have sex with the same person twice	9.3%	9
Don't do some act (e.g. kiss) with others	6.2%	6
Only fuck, never be fucked	4.1%	4
Don't have group sex	2.1%	2
Only have oral sex with others	2.1%	2
None of the above	21.6%	21

The theme of intimacy, as something reserved exclusively for the primary partner, was present in many of these responses. For example, the most commonly chosen response to this question (32%, N: 31) was the 'don't sleep over' rule as part of their relationship agreement. This suggests that there was a distinction between sexual acts and intimacy, with the latter being limited to the primary relationship. Other responses such as 'don't have sex in our home/s' and 'don't do some act with others' also contributed to this belief. As R24, the respondent in a 'monogamish' relationship discussed above, who limited anal sex to his primary relationship, stated:

'...it [using condoms with others] also prioritises our relationship and maintains something intimate that we do for ourselves.'

(R24, aged 31-40)

It also became clear that the idea of intimacy ran through the majority of responses from men who had broken their relationship agreement. 'Barebacking', 'having sex at home' and 'sex with regular partners' were the main ways respondents identified how they broke their relationship agreement. For example, R501 stated that he specifically broke an element of the relationship agreement by engaging in an intimate way with a sex partner:

'Formed a more intimate relationship than our agreement prescribes.'

(R501, aged 51-60)

This focus on intimacy as something exclusive to the primary relationship was repeated in many of the responses from men in open relationships. There appeared to be a separation between certain sexual acts and intimacy, which allowed these men to maintain their open relationship. This meant that they could have some forms of sex with other men, while the more intimate acts were preserved for the primary partner. In turn, their primary partner appreciated this intimacy and understood that this was exclusively for him. Therefore, exclusivity was maintained in open relationships in much the same way as it was in monogamous ones. The

main difference was that while all sexual acts were exclusive in the monogamous relationship, intimacy was exclusive in open ones. It was when this intimacy was shared with other men, whether in the form of barebacking, having sex with the same man regularly or having sex at home, that open relationships were deemed to have been broken.

As previously discussed, relationship agreements were complex and varied according to each situation. To gain a greater understanding of the detail of these arrangements, respondents were asked two direct questions about their use of casual and/or regular partners and condom usage with other men. Over half of the respondents (53.9%, N: 55) stated they had no arrangements about the use of casual/regular partners. To some, this might be an unimportant aspect of their relationship agreement, but for others they might be unclear about their primary partner's preference on this matter. This suggests that relationship agreements might not be as detailed as one might expect. However, when it came to condom usage, almost three out of every five respondents (58.6%, N: 58) stated that they had an arrangement to use condoms at all times with other men. This might be seen as a reliable arrangement to protect the primary partners from HIV/STI infection. However, given the earlier discussion of intimacy, it might also be interpreted as a means to keep the more intimate practice of barebacking within the primary relationship. As R23 stated, a condom not only breaks intimacy, but also a 'spiritual connection' with a partner:

'[A condom] limits the intimacy and spiritual connection that can occur without it.'

(R23, aged 41-50)

Therefore, while one objective of having rules about condom usage with other men was the reduction of HIV/STI risk, the second explanation was that it might be a way to protect the intimacy of barebacking for the primary partner.

A further 25.3% (N: 25), had no agreement about using condoms with other men, only eight of whom were seropositive. Once again, this points to a lack of detail in some relationship agreements. As R19 pointed out when speaking about condom usage with other men, relationship agreements might be implicit rather than explicit:

‘No agreement, but we both know [what] we would do.’

(R19, aged 18-24)

Indeed, some respondents who indicated that they had broken an element of their relationship agreement also specified that the behaviour they had engaged in was not part of their specific relationship agreement. For example, both R65 and R403 revealed that they had broken their relationship agreement because they had engaged in bareback sex with another man. Yet, both also stated that they did not have an arrangement with their primary partner about using condoms with other men. Even though these respondents had not agreed to use condoms with other men, it was obvious from their responses that they felt that it was implicit in their agreement. Therefore, it was evident that the lack of clarification in such agreements may create difficulties both for the definition, and the enacting of, an open relationship.

If some relationship agreements were implicit, as the evidence suggests, and clarification about use of regular/casual partner and/or condom usage were not made, then misunderstandings between primary partners might occur, possibly causing hurt and leading to the eventual dissolution of the relationship. However, these misunderstandings might also have serious consequences for the sexual health of the primary partners. While the use of casual partners might have minimised the potential of feelings developing for other men and hence protected the primary relationship, they might also have increased the possibility of HIV/STI infection, especially if condoms were not used. The implication of not having an agreement about the use

of condoms with partners had a more obvious impact on the possibility of such infection, particularly if both the primary partners were seronegative.

Conclusions

The completion rate for the survey was 65%. Although this did not reach the level reported for some online surveys, it was higher than many others. However, given the time commitment and the sensitive nature of questioning in this sexual health survey, I was pleased with the completion rate achieved. The majority of respondents were from younger age groups, lived in a variety of urban centres in England, were poly-drug/alcohol users and identified as white and gay/homosexual. A significant proportion of those who lived in urban centres hailed from outside the twelve cities and towns listed in the survey revealing the reach of this internet survey. Even though some respondents admitted to being attracted to women at times, they were more likely to identify as gay/homosexual than use other terms. While poppers was the most commonly used drug by respondents, other drugs such as marijuana, ecstasy and erectile dysfunction drugs were also used. However, drugs were often used in combination with alcohol and/or other drugs and the majority of respondents were aware of the effect this had on their decision-making capabilities.

Almost ten percent of respondents to the survey identified as being seropositive, while seventy percent stated that their last test was seronegative. A further fifteen percent stated that they had never tested for HIV or any STIs, while four percent had tested, but not received, a HIV test result. This indicated that almost twenty percent of respondents to this survey had never been tested for HIV and/or received a HIV test result. Of those who had tested, over two-thirds tested at least once a year. This signified regular testing among those who have tested. Nevertheless,

these findings also indicated that sexual health promoters need to do more to target those who were not testing and those who were not testing on a regular basis.

Over three in every five respondents to this survey were in a relationship. All respondents, both single and those in relationships, held primarily positive views of monogamy. While the vast majority felt that any form of oral or anal sex with another man was a breach of monogamy, a number felt that their definition of monogamy would be more flexible if their partner lived away from home and/or the sex happened in a more anonymous setting. However, qualitative responses indicated that monogamy was something that was more fluid than stable. This was embodied in what R24 referred to as his 'monogamish' relationship. Details collated from those in open relationships revealed that relationship agreements were more implicit than explicit and prioritised intimacy within the primary relationship. Therefore, open relationships were formed in much the same way as monogamous relationships. While all sexual acts were exclusive in monogamous relationships, acts of intimacy were exclusive in open relationships. Three out of ten men in 'monogamous' relationships had sex with another man during periods of monogamy in their relationship. However, a similar number of men in open relationships had also broken an element of their relationship agreement indicating that these relationships provided no better forms of protecting primary partners from HIV/STI infection, even though many men in open relationships emphasised the honesty in these relationships vis-à-vis monogamous ones. It was evident therefore that the beliefs about open relationships being more honest needed to be challenged, so that these men gain a greater understanding of the potential HIV/STI risk they posed to their primary partner and/or their primary partner posed to them.

Chapter Six – The Risk Landscape

‘I find the prospect [of sex with a seropositive man] terrifying. Even if a condom is used, it is not 100 per cent safe. The risk would not be worth it for me.’

(R363, aged 18-24)

Introduction

Initially, this chapter will examine the sexual risk practices of respondents and explore how commonplace these practices are in the MSM communities among those who are single and those in relationships. It will examine the frequency of bareback sex across age groups and sexual roles. Given that they are likely to be at higher risk of acquiring HIV, a similar investigation will be carried out on those who have intentionally sought bareback sex with someone other than a CRP. While semen exchange may prove to be important to these men, I will also explore whether or not these men embrace the term 'bug-chasers', or if they have previously engaged in various risk reduction strategies to minimise their risk of HIV acquisition. Given the relationship between masculinities and risk-taking discussed in the literature, an examination of the language used by such risk-takers will also be examined.

Taking into consideration the high participation rates in bareback sex revealed in the survey, it is perhaps surprising that a substantial majority of respondents did not see themselves at risk of acquiring HIV. Therefore, an examination of a number of high-risk activities will be carried out to explore if respondents believed that these activities significantly increased their risk of acquiring HIV. In addition to their own activities, seronegative men were asked to assess their risk of HIV acquisition from seropositive men. These results revealed that knowing someone who is seropositive, or someone who has died of an AIDS-related illness (SPDARI) affected respondents' understanding of their risk from other seropositive men. However, many other respondents revealed outdated understandings of their HIV risk from seropositive men.

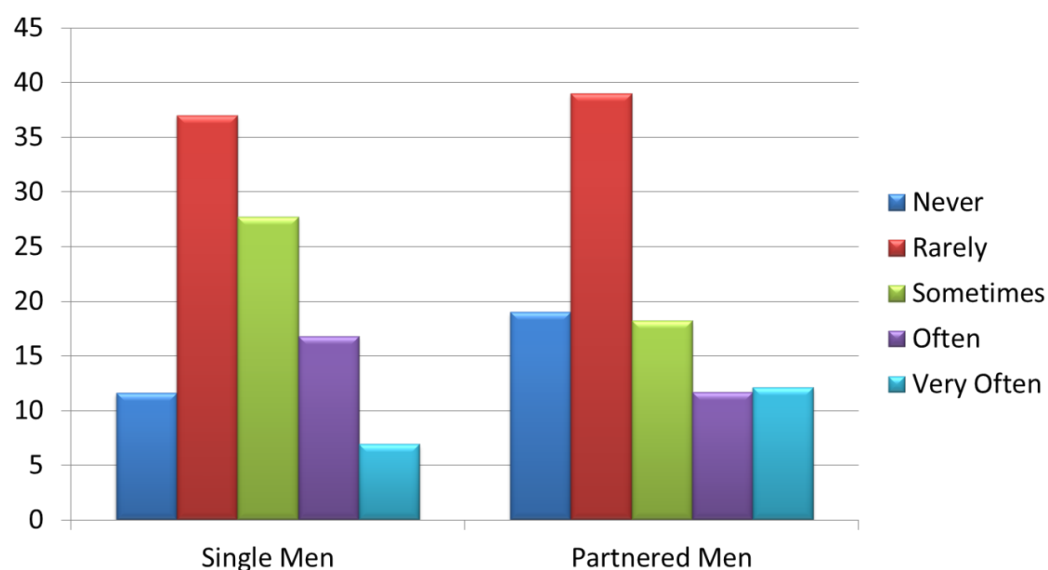
Respondents' risk-taking

Respondents to the survey were asked several questions to profile their sexual risk-taking activities. The results indicated that almost three quarters of all respondents (73.7%, N: 407) engaged in bareback sex with someone other than a CRP at some stage in their sexual careers. Those who were seropositive were more likely to have engaged in bareback sex with someone other than a CPR (94.5%, N: 52) than seronegative respondents (76.3%). Those who were single were only slightly less likely to have had bareback sex (78.7%, N: 174) than those within relationships (82.5%, N: 274). The highest level of bareback sex occurred in relationships of one to two years (94.8%, N: 55). However, those in shorter-term relationships (< 6mths) were less likely to have engaged in bareback sex with their relationship partner (54.5%, N: 18) than those in longer relationships. Nevertheless, these results indicated widespread acceptance of barebacking in the MSM communities, both among those who are single and those in relationships.

I. Type of respondents engaging in bareback sex

When asked to estimate frequency of bareback sex with someone other than a CRP, similar trends emerged between single (S) and partnered (P) men, particularly among those who stated they have bareback sex 'rarely' (S: 37%, N: 64; P: 39%, N: 90). Those who were in relationships were more likely to never have had bareback sex outside relationships (P: 19%, N: 44) than their single counterparts (S: 11.6%, N: 20). However, those within relationships who did have bareback sex with others were almost twice as likely to have bareback sex 'very often' (P: 12.1%, N: 28), in comparison with single respondents (S: 6.9%, N: 12). These figures are presented in figure 6.1.

Figure 6.1: Single/Partnered frequency of bareback sex outside relationships



Bareback sex with someone other than a CRP was common across all age groups. At least three quarters of all respondents in the four age categories above 25yrs have had bareback sex with someone other than a CRP. However, the frequency of bareback with someone other than a CRP was slightly less common among those aged 18-24 (63%, N: 87). This might be because they were at an earlier point in their sexual careers than other age groups. Interestingly, percentages of those aged above 25 who have had bareback sex with someone other than a CRP remained almost constant between 75.5% (N: 37) of those aged over fifty to 77.3% (N: 102) of those aged between thirty-one and forty.

Examining the sexual role of respondents and bareback sex with someone other than a CRP showed no significant difference between roles. However, those who described themselves as bottom-only were slightly less likely to have had bareback sex with someone other than a CRP (68.7%, N: 46) than those taking other roles. It was possible that those who were bottom-only had greater awareness of their risk of HIV infection. Those who described themselves as mainly-bottom were most likely to have had bareback sex with someone other than a CRP (77.2%, N: 105). While those identifying as mainly-bottom could have taken either role during anal sex,

only 19% (N: 11) of these respondents stated that they were likely to take an active role when barebacking as a means of risk reduction. Therefore, while at a slightly lower risk of acquiring HIV than their bottom-only counterparts, those who are mainly-bottom might have a heightened sense of safety in relation to their risk of HIV acquisition.

II. Respondents Intentionally Seeking Bareback Sex

Given that respondents who intentionally sought bareback sex might be considered at higher risk of HIV acquisition/transmission, I thought this was worthy of further exploration. All respondents who had previously admitted to engaging in bareback sex with someone other than a CRP (N: 406) were asked if they had ever intentionally sought bareback sex. Almost three out of five respondents (57.4%, N: 233) stated that they had not intentionally sought bareback sex from a partner. This suggests that the majority of those engaging in bareback sex had not intentionally sought it, but found themselves in situations where they had engaged in this form of sex. A further 4.7% of respondents (N: 19) stated that they did not know, or were unsure, if they had intentionally sought bareback sex. Both these groups might benefit from targeted mass media interventions addressing anticipation of opportunities and awareness of strategies to deal with such situations.

The remaining 35.5% of respondents (N: 144) had intentionally sought bareback sex. However, it was clear from the results these respondents did not wish to acquire HIV. Just three percent of these respondents (3%, N: 12) identified as 'bug-chasers' - defined in the survey as someone who deliberately tries to become infected with the HIV virus. Further analysis revealed that these twelve respondents were either seropositive already (and therefore could not be actively seeking infection) or had engaged in at least one of the various risk reduction strategies to protect themselves from becoming infected. All had serosorted at some stage, while others

utilised strategic positioning and/or withdrawal²⁹. Therefore, it was evident that the vast majority of respondents who had intentionally sought bareback sex from someone other than a CRP were not seeking to become infected with the HIV virus. While some respondents were happy to identify as ‘bug-chasers’, their engagement in the various risk reduction strategies revealed that this was not the case.

III. Sexual risk-taking and the discourse of masculinities

A small number of respondents discussed sexual risk in the context of masculinities. When questioned about how they compared themselves with the two images of men presented to them³⁰, it was evident that many respondents associated the more masculine image (Image B) with risky sex. Even though condoms were central to image A, suggesting that sex was forthcoming, many respondents identified the men in image B as being sexual in nature, who were often described as ‘seedy’ (R289) or sexually casual (‘up for a quick fuck’ - R218). More directly, R40 associated the more masculine image (those ‘who spend a lot of time in the gym’) with rough, unsafe sex:

‘[Image] B looks like two guys who spend a lot of time in the gym and look like...men who are into S&M, dark rooms and rough (perhaps unsafe?) sex.’

(R40, aged 41-50)

These responses indicated that respondents made an association between images that they identified as masculine and certain sexual risky activities.

²⁹ These risk reduction strategies are discussed in more detail in chapter eight.

³⁰ The images of these men are presented in Appendix Three.

Semen exchange has been linked with masculinities in the literature and proved particularly important for some men who have bareback sex with someone other than a CRP. Of those who were asked about semen exchange, over half (51.6%; 209) chose to give additional information in an open-text response box. Receiving semen during anal sex was deemed more important (41.3%, N: 154) than giving semen to their partner (36.9%, N: 140). As one would perhaps expect, semen exchange was most important for those who identified either exclusively top (55.2%, N: 16) for giving semen or exclusively bottom (56.8%, N: 25) for receiving semen. However, the small number of respondents identifying in these exclusive categories might distort these percentages. These responses pose particular difficulties for those engaged in the field of sexual health. Receiving semen from a partner is a particularly high-risk activity. Given the centrality and importance of this activity for men who seek bareback sex, it might be difficult for sexual health promoters to challenge such behaviour. The draw of semen exchange for these respondents might be so considerable that it mitigates against any benefits that can be provided by the use of condoms.

Owing to the importance of semen as a definer of masculinity, it is perhaps no surprise that these men spoke about semen (often referred to as 'cum' or 'come' by respondents) contextualised within a broader masculine discourse. Semen exchange, particularly during receptive anal sex, presents the highest risk for the transmission of HIV. While some respondents expressed an active dislike of semen, others expressed a desire to receive semen orally, but not anally. However, the following seropositive respondent described the centrality of semen exchange to his sexual encounters.

'It's hard to explain, but there seems to be a *primal drive* to give and receive cum.'

(R344, aged 41-50, emphasis my own)

Semen was not simply a liquid for some respondents, rather it represented something far more significant. The following seropositive respondent attempted to describe the meaning of semen to him:

‘It is swapping a piece of your ‘essence’.’

(R223, aged 51-60, emphasis respondent’s own)

In describing semen as an ‘essence’, R223 redefined semen as a quality that was an intrinsic and indispensable part of himself and/or his partner. In this context, semen was transformed from a liquid into something that was unique and an essential part of the respondent’s and/or his partner’s persona.

While the respondents above expressed the importance of semen to their sexual encounters, the following respondent described semen more directly in the context of masculinities. For him, receiving semen is the ‘most masculine part of sex’, something which he ‘craved’ inside him. Being in the receptive position, which many have traditionally associated with the feminine, this respondent became masculinised through the process of receiving semen.

‘It is ultimately the horniest and most masculine part of sex - the cum I mean. I kinda crave it in me. I really get off on that.’

(R264, aged 41-50)

The urge to give and/or receive semen is interrupted by the use of techniques to minimise sexual risk. In the quote that follows, R184 spoke of his experience of withdrawal and the effect that it had on his experience of receiving semen. If he did not receive semen, he felt as if he was not ‘good enough’, like a ‘let down’ and that it was ‘almost pointless’ having sex in the first place. For this respondent, it was not the act of barebacking itself that was important, but receiving semen from his partner.

‘To withdraw without coming or someone else withdrawing before they have come feels like a ‘let down’, like you weren’t good enough or like it was almost pointless having sex if you’re going to finish by masturbating. From a receiving point of view I want to feel a cock throb while it ejaculates and feel the warm come inside me.’

(R184, aged 25-30, emphasis respondent’s own)

This importance of semen to men presents difficulties for sexual health promoters trying to promote condom usage. R535 spoke about the ‘barrier’ of condoms and the affect that this has on many men’s ‘prowess’. The choice of this word is noteworthy, as it is connected with strength, most particularly strength in battle. The connection between prowess and masculinities here becomes obvious. From this perspective, the condom becomes a challenge to masculinities, whether that person is in the dominant or submissive position in sex.

‘In my experience, very few men like the barrier of condoms, whether top or bottom. Many believe it affects their prowess.’

(R535, aged 41-50)

However, there was also a small number of other respondents who associated condom use with masculinities. For these respondents, there was a clear association between taking responsibility for one’s own health and masculinities (‘man up and strap up’ – R509; ‘the real men will accept this [condom use]’ – R377). Interestingly, none of these respondents had themselves engaged in bareback sex with their sexual partners.

The centrality of semen exchange to some men’s sexual experience creates a number of difficulties for sexual health promoters. As long as men see semen exchange as fundamental to the sexual encounter, which sixteen respondents (7.7%) did, the promotion of condom usage will remain challenging. When these notions about semen are also tied with masculinities, the

challenges will remain as men seek to become masculinised through their ingestion of their partner's semen.

Seronegative respondents' understanding of their risk of HIV

This section of the chapter explores how seronegative respondents understand their risk of HIV acquisition. It examines respondents' understanding of HIV risk from certain sexual activities and from seropositive men in particular.

I. Seronegative respondents' understanding of risk by sexual activity

The majority of seronegative respondents (65.7%, N: 329) felt that, given their sex lives, they were not at risk of acquiring HIV, while just over a fifth believed they were at risk (21.4%, N: 107). The remaining thirteen percent were unsure if they were at risk of acquiring HIV, suggesting that they were unsure whether their sexual practices had put them at risk.

However, a similar percentage of respondents (61.3%, N: 217) did not see having bareback sex with someone other than a CRP as something that would significantly affect their risk of acquiring HIV. It was possible that those who did not see this bareback sex as a risk had since tested for HIV and no longer believed that the specific encounter constituted a risk. Of those who had intentionally sought bareback sex, a significant minority (44%, N: 48) were aware that their sexual activities may put them at a higher risk of acquiring HIV. However, the majority of these respondents either disagreed that they were at risk (40.4%, N: 44) or were unsure (15.6%, N: 17). Given the risks associated with serosorting, only 34.1% (N: 56) of serosorters believed that they were at risk from acquiring HIV. These results indicate that those who engaged in some of the highest risk activities did not see themselves at risk from acquiring HIV.

Given that testing positive for an STI is an indication of sexual risk (although not necessarily involving anal sex), I thought this was worthy of further examination. Just under a third of respondents who had tested positive for an STI (31.1%, N: 61) felt they were at risk of acquiring HIV. However, if respondents were diagnosed with more than one STI at the same time, they were far more likely to consider themselves at risk of acquiring HIV (55.6%, N: 15). In fact, this was the only grouping where a majority of respondents saw themselves at risk of acquiring HIV. This suggests that while respondents did not see testing positive for an STI as a significant risk, those who were diagnosed with more than one at the same time understood that their sexual practices might be putting them at risk of acquiring HIV.

II. Seronegative respondents' understanding of HIV risk from seropositive men

Seronegative respondents were asked if they ever had, or would consider having, sex with a man they knew to be seropositive. Over three out of five respondents (62.3%, N: 312) stated they never had, or were unsure about having, sex with a man they knew to be seropositive. Of these respondents, 56.9% (N: 177) knew someone who was seropositive, or who had died from an AIDS-related illness (SPDARI). Of those who would have sex with seropositive men, over three quarters (77.1%, N: 145) did not know any SPDARI. This suggests that while seronegative respondents who knew SPDARI were open to the possibility of having sex with other seropositive men, while those who did not know any SDARI were more open to the idea of having sex with them.

While discussing why they would not have sex with seropositive men, many respondents contextualised their responses in terms of risk. However in many of these responses, risk was often left undefined. R491, who does not know any SPDARI, stated that there was 'no point taking risks that high' (aged 51-60). Many respondents also expressed a 'fear', or of being 'terrified', of seroconverting, even if condoms were used with seropositive men. This was a

theme repeated by those who knew no, or the fewest number of, SPDARI. For R218, this fear could affect sexual performance ('would be to[o] afraid of getting HIV to get in the mood', aged 25-30), while for others the impact could be far wider. For example, R417 stated that this fear has affected him since he was a teenager and had impacted upon his ability to become sexually fulfilled:

'My fear of getting STDs has always been so fierce that it's affected my sex life since [being a] teenage[r]. I've never fulfilled what I wanted to in sex because I'm too afraid of getting infected, therefore I'd never have sex with someone I knew had HIV.'

(R417, aged 31-40)

For other respondents, fear of condom failure dominated their responses. These respondents accepted that condoms do not work all the time and the possibility of infection, however small, was something they would not consider risking. Risk in these cases was defined in terms of condom failure. R504, who knew between one and five SPDARI, but has never himself received a HIV test result, stated:

'Higher risk of transmitting something if condom bursts.'

(R504, aged 31-40)

Many younger respondents (aged 18-24) who had never tested for HIV, or had never received a HIV test result, spoke of HIV in terms of death. In the quotation that follows, R246 makes such an association, but also said that he would 'infect anyone else I had sex with' if he seroconverted. This indicated that he felt there is no way to control the virus once infected:

'Because they are carrying a dangerous STI that can lead to death, and it spreads so I would infect anyone else I had sex with if it had sex with this HIV positive person,

even if a condom was used there is still risk of the disease been transmitted, e.g. condom ripped.'

(R246, aged 18-24)

These responses revealed a lack of understanding about the development of antiretroviral medicine since the late 1990s. This was interesting, as these respondents would not have been born, or would have been too young to remember, a time when people in the Western World died of AIDS-related illnesses, yet expressed clear associations between HIV and death. It was possible that such misunderstandings could have been dispelled if these respondents had more contact with sexual health professionals.

Of those who were more open to the possibility of having sex with seropositive men, many gave conditional responses. These conditional responses often centred on the requirement of a degree of commitment and/or a long term relationship before having sex. However, these men did not clarify how they would have reached this stage of relationship without having sex. R528 stated that he believes he would have safer sex with a seropositive partner in the context of a relationship, but would have to confirm this if he found himself in the situation:

'If I met and became in a relationship with someone who was positive I would have safe sex with them I think but would have to be in the situation to know for sure.'

(R528, aged 25-30)

Nevertheless, several respondents who expressed strong fearful opinions about having sex with seropositive men were willing to take risks with men they believed to be seronegative. For example, R280 stated that he would not have sex with someone he knew was seropositive as he would be 'purposely' placing himself at risk of acquiring HIV, which he described as 'potentially life threatening'. However, further analysis revealed that R280 had never tested for HIV, had intentionally sought bareback sex from someone other than a CRP, had not used any risk

reduction strategy, and did not feel, given his sex life, that he was at risk of acquiring HIV. Even though R280 would not have sex with seropositive men, he was engaging in a series of high-risk sexual activities, which he felt did not put him at risk of acquiring HIV:

‘I would not purposely put myself in a situation where I could catch a disease which is incurable and potentially life threatening.’

(R280, aged 18-24)

Therefore, while many seronegative respondents spoke of fear of acquiring HIV as a result of having sex with seropositive men, some of these were willing to engage in high-risk behaviours with people they knew, or presumed, to be seronegative. So while these respondents understood sexual risk with seropositive men, they failed to understand the risks they were taking in their own sex lives.

Conclusions

It was evident that the practice of barebacking was common among men of all ages, sexual roles and relationship statuses in the MSM communities. However, it was clear that these men were not setting out to become infected with HIV, even though they might have intentionally sought bareback sex from their sexual partners. While they took various sexual risks, the majority did not see themselves at risk from acquiring HIV. It was only when a respondent was diagnosed with two STIs at the same time that a slight majority of respondents understood they were at risk of acquiring HIV. Interestingly, a masculinities discourse emerged in line with risk-taking activities, most notably semen exchange. To this small number of men, semen was more than a liquid, but something that was intrinsic to the respondent and/or their sexual partners. For these respondents, to try and separate the partner from his semen through the use of condoms and/or risk reduction strategies was counterproductive.

However, many respondents expressed reluctance to have sex with seropositive men, as this was considered to be too large a risk, even if condoms were used. Many of these respondents contextualised their responses in terms of risk, but did not clarify how they defined that risk. Some younger respondents held dated opinions about an association between HIV and death, even though they were too young to remember a time when people died of AIDS-related illnesses. However, attitudes towards sex with seropositive men improved if the respondents knew someone who was SPDARI. However, men who expressed fear of having sex with seropositive men also took a wide variety of sexual risks with men they presumed to be seronegative without acknowledging the risks they took in their own lives.

Chapter Seven – Evolving Moral Discourses

‘I’m feeling burned out with continually ‘being good’. [The] rest of the world has not got a clue about the energy and self-discipline this takes.’

(R30, aged 51-60, emphasis respondent’s own)

Introduction

In the previous chapter, it became evident that many respondents were engaging in risky sexual activity, but did not necessarily see this as exposing them to the risk of acquiring HIV. Therefore, it was necessary to understand how respondents spoke about HIV risk in the qualitative responses. Many respondents spoke directly about those they thought were most at risk of acquiring HIV and a particularly strong moral discourse about HIV risk emerged from the analysis. This dominated discussions about the use of PrEP and Juan's story, as presented in the vignettes³¹. While PrEP remains widely unavailable on the NHS at time of writing, a number of discourses are emerging from the United States where PrEP is more widely available, most notably that of 'PrEP-whore' shaming (Spieldenner, 2016). Questions in the survey about PrEP allowed for an investigation of the current opinions about PrEP in the UK at this opportune time. The purpose of creating Juan's vignette was to construct a story about an emigrant to London from an unspecified religiously conservative country, who discovers sexual freedom in the city. Juan attends saunas and sex clubs and is pressurised by other men not to use condoms and, on reflection about the developments in antiretroviral medicines, decides not to be as insistent about their use. While respondents may not have related to Juan's use of sex clubs, the main themes that ran through his story, sexual repression and subsequent liberation, are similar to those in many MSM's coming-out stories. Therefore, it was hoped that respondents would relate to these themes as they represent some of the core issues that MSM face in their earlier lives.

However, a strong moral discourse evolved in the responses from respondents across all ages, relationship statuses and whether or not they had previously engaged in/intentionally sought

³¹ See Appendix Four.

bareback sex. A wide variety of derogatory terms were used to describe Juan's risk-taking, which seems to be in conflict with the celebration of sexual transgression that was previously evident in the MSM communities. This evolving moral discourse had a number of key consequences for respondents. Many wished to distance themselves from men who were seen to engage in sexual risk-taking. Even those who related to Juan's dilemma still distanced themselves from his behaviour. However, it became clear that those who were maintaining such a moral high-ground were also engaging in risk-taking behaviours that were not dissimilar to Juan's.

Further analysis revealed that these respondents felt they were able to maintain a moral high-ground *vis-à-vis* Juan by investing in the creation of an *other*, with whom they contrasted themselves in order to minimise the importance of their own risk-taking. Embedded within these creations of the *other* were clear dichotomies of right/wrong, good/bad behaviours and responsible/irresponsible risk-taking. The most common way for respondents to distinguish themselves was to contrast their own sexual activity with that of a sexually risky *other*. Further ways in which respondents created an *other* was to differentiate by age and by participation in the commercial gay scene. The creation of this *other* allowed respondents to sanitise their own risk-taking through the comparison with these imagined *others*.

Those who are deemed to be an *other* were also believed to be irresponsible in other aspects of their lives and hence, their whole character was stained. However, when respondents explained their own sexually risky behaviour, they did so by describing it as infrequent and contextualising it in terms of loss of control. The emphasis on both these aspects meant that the respondents were able to justify their own temporary engagement with sexually risky behaviour and maintain their unstained character in a way that was not made available to the *other*.

It became clear that respondents were using the creation of the *other* and making use of the aforementioned justifications to sanitise their own previous sexually risky behaviours and to distance themselves from the irresponsible *other*. However, in doing so, they were also minimising the importance of their own sexual risk-taking and identifying the imagined *other* as the person at risk of HIV acquisition/transmission. Consequently, as a result of this investment in the *other* as a sexual risk-taker, these men were unlikely to identify their own sexual risk-taking as something that placed them at risk of HIV acquisition.

The Moral Discourse

It became evident from the responses that the majority of respondents across all backgrounds held very strong moral opinions about sexual risk-taking and those who were seen to be putting themselves at risk of acquiring HIV. While evidence of moral opinions was identified in the literature, the opinions that emerged in this research were often expressed forcibly and stretched far beyond the condom code. Nowhere was this stronger than in respondents' discussions about Juan's decision not to be insistent about condom use in saunas and sex clubs. Even though respondents were asked to take the role of Juan's friend, a wide range of derogatory terms, such as 'whore', 'slut', 'dick', 'arsehole', 'twat' and 'idiot' dominated descriptions of Juan, while his actions were often defined as 'dumb', 'stupid', 'irresponsible' and 'ridiculous'. Many of these terms were used as one word answers, which emphasised the strength of opinion and the immediate dismissal of Juan's behaviour. However, others were used in a wider context. For example, R466 used a variety of such terms to describe men who frequent saunas/sex clubs:

‘You’re [Juan] an idiot. The sluts and whores frequenting that place can probably, between them, infect you with everything going. Also, that you even go to them is profoundly icky.’

(R466, aged 25-30)

Without question, R466 labelled those who frequent sex clubs as ‘sluts and whores’, who he felt were likely to infect Juan with ‘everything going’ [STIs/HIV]. For this respondent, even attending such venues was ‘profoundly icky’. Therefore, it was evident that R466 made strong moral judgements about men who attended such clubs and the increased HIV/STI risk he associated with such locations. In a similar way, several other respondents stated that they would no longer be able to maintain a friendship with Juan because of his behaviour. It was clear that these respondents felt that maintaining a friendship with someone who took sexual risks might implicate them in such practices and hence impact on their ability to source partners. Therefore, the stigma attached to men who took sexual risks was one that these respondents wished to disassociate themselves from. The result was that distance had to be established between the respondent and Juan.

‘He is a narrow minded prick. He would no longer be accepted within my group of friends.’

(R236, aged 25-30)

Speaking about the use of PrEP, the following respondent contextualised his response more directly in moral terms. It was evident from this response that he did not approve of PrEP, as it ‘promotes dangerous sexual practices’ i.e. barebacking, even though the risk associated with barebacking is significantly reduced by the use of PrEP. There was also the suggestion that R370 sees the alternatives to PrEP, i.e. consistent condom usage, as a guarantee of not acquiring HIV, even though this had proven a challenge for some of his ‘sexually risky friends’. The division

between good (i.e. consistent condom usage) and bad behaviours (i.e. barebacking) was clearly framed in moral language of right and wrong.

‘Morally I would expect people not to even consider this PrEP as it is not a guarantee and, in my eyes, promotes dangerous sexual practices, but I know anecdotally from my own friends the increase[d] taboo of barebacking and how sexually risky friends of mine are despite knowing all the dangers.’

(R370, aged 25-30)

While R370, as a committed condom user, might not have been able to completely relate to Juan’s decisions, other respondents, who understood Juan’s reasoning, were also critical of his decisions. For example, while R495 related to Juan’s dilemma between popularity and his use of condoms, he was also clear that he would tell Juan that his decision was ‘not the correct one’. This suggests that those who might have found themselves in positions of not using condoms previously would also be equally critical of Juan’s decisions and hold moral opinions about what they believed the ‘correct’ course of action should be.

‘Although I understand his decision not to use condoms to improve his popularity, as I would feel the same, I still am aware and would tell him it’s not the correct one.’

(R495, aged 31-40)

However, what was interesting about those who maintained a moral high-ground was that their own sexual behaviour was not always too dissimilar from those who they labelled as risk-takers. In the quote that follows, R256 branded Juan an ‘idiot’ for his behaviour and made a clear association between HIV and death. While misinformed about this association, it was clear that R256 understood that Juan’s decision not to use condoms was high-risk. However, R256 had himself intentionally sought bareback sex from someone other than a CRP and had never tested

for HIV or other STIs. This behaviour placed R256 at a high risk of acquiring and subsequently transmitting HIV/STIs to others. Yet, he labelled Juan as a 'complete idiot' for his behaviour.

'He is a complete idiot, the grave yard is full of such people.'

(R256, aged 51-60)

While some men were able to take a moral high-ground in relation to other men's high-risk behaviour, they did not always see it reflected in the sexual risks they took in their own lives. It was possible that men who made moral judgments about other men who took sexual risks may see them as an *other*, whose behaviours they contrasted with their own to minimise the importance of their own risk behaviour.

The discourse of 'the *other*'

In their discussions of risk-taking, many men identified an *other* as a sexual risk-taker. Embedded within this *othering* process were clear dichotomies between 'them and us', 'good and bad' and 'responsible and irresponsible'. Respondents often identified their own risk-taking as responsible, while making moral judgements about the actions of others, who were deemed to be irresponsible. By using this process, the men who were to blame for spreading HIV were those who engaged in what respondents recognised as irresponsible/bad behaviour, while also minimising their own role in that process. There were many ways men identified this *other*, but the most reoccurring ways were through sexual activity, scene participation and age. However, there was often disagreement about the definitions of terms such as promiscuity, or who were more responsible (younger/older men).

I. Sexual Activity as the *other*

Perhaps unsurprisingly, a number of men identified those *others* who were more promiscuous than themselves as being most at risk of acquiring HIV. Men in monogamous relationships across all ages often used their relationship status to differentiate themselves from this promiscuous *other*. For example, R470 who was in a long term monogamous relationship with his partner, differentiated between himself, as the responsible actor, and ‘men with multiple partners’. In doing so, R470 was creating distance between men like him, who were in monogamous relationships, and those who he thought were less responsible:

‘Men with multiple partners would consider any option to lower risk of becoming positive.’

(R470, aged 41-50)

However, the following respondent went further and created a more direct comparison between those who were promiscuous and those, like himself, who were in more committed relationships. In this case, R506 was establishing a clearer moral split between himself, as the responsible actor, and those single promiscuous *others*, who were engaging in irresponsible behaviour.

‘I think men who are very sexually active/promiscuous would be more likely to take it [PrEP] than those in long term committed monogamous relationships.’

(R506, aged 25-30)

Even though single respondents could not make reference to a relationship, they still compared themselves more favourably in comparison to those they believed to be promiscuous. In the quote that follows, a younger single respondent, who has had between one and five sexual partners in the last year, discusses how some more promiscuous men might need PrEP to reduce

their risk of acquiring HIV. Therefore, a similar moral discourse emerged with single men as it did with men in monogamous relationships. The implication was that he, as a man with a fewer number of partners, was not at such a risk, while the *other* were men with a larger number of partners:

‘Some more promiscuous men may take the drug [PrEP] so they feel less at risk.’

(R230, aged 18-24)

An individual has only to be identified as potentially promiscuous in order for him to be considered a risk. In the quotation that follows, the respondent, who was in an open relationship, was reacting to one of the images from a mock profile (*Hungasahorse*³²). In this case, R400 (who reported having four to seven partners outside his primary relationship in the last year) identified the man in the mock profile image as someone who ‘might lead a more promiscuous lifestyle’ and therefore at risk of acquiring HIV. The use of the word ‘more’ suggests that he considers those who have more partners than himself to be the *other*:

‘he might lead a *more* promiscuous lifestyle and is [therefore] more vulnerable to contracting HIV.’

(R400, aged 31-40, emphasis my own)

Given the variation in number of partners between respondents making similar comments (i.e. R400 who has had a greater number of sexual partners than R230), it was clear that the definition of promiscuity varied between respondents. Therefore, there was no constant definition of promiscuity and, consequently, the description of the *other* was also likely to vary between individuals. However, what was clear was that all these respondents wished to distance themselves from the *other*, who was deemed to be irresponsible in relation to HIV risk, while also underscoring what they defined to be their own moral/good behaviour.

³² See Appendix Two

While some respondents spoke directly about promiscuity, others spoke about ‘high-risk’ sexual lives. In these cases, respondents might have been referring to promiscuity, but this term could also have signified other forms of sexual activity, such as barebacking. The following respondent, who never had bareback sex and only had a small number of partners in the last year, identified the *other* as a person who had a high-risk sex life. However, it remained unclear how he specifically defined this term:

‘[PrEP is]...useful in risk reduction in persons with high risk sex lives.’

(R461, aged 51-60)

As with promiscuity, ‘sexual risk’ was open to interpretation. In comparison to R461, the following respondent had intentionally sought bareback sex from a small number of partners. While he defined his sexual role as ‘top only’, which considerably reduced his own HIV risk, he saw those who were taking ‘sexual risks’ as the *other* in need of PrEP, in comparison to those who took their ‘sexual health seriously’. While he does not overtly identify himself as someone in the latter category, it was clear from the dichotomy presented that he felt he was the one who took his sexual health seriously:

‘The ones who take more sexual risks, it’s [PrEP] a no brainer. Those who take sexual health seriously are unlikely to put themselves knowingly into situations where PrEP would be needed.’

(R164, aged 31-40)

To R164, those who took their sexual health seriously did not ‘knowingly’ put themselves at risk. The use of this word allowed for the possibility that men who took their sexual health seriously might, nevertheless, unknowingly put themselves at risk. Given that the context of this quotation was the use of PrEP, it was evident that the respondent felt that there might be ways

for men to take sexual risks in the knowledge that they were not putting themselves at risk of acquiring HIV.

When men were deemed to be irresponsible in their sex lives, they were also labelled as irresponsible in other areas of their lives and hence their character was stained. For example, in the following quotation, R371 stated that PrEP would not be successful as he believed those who needed it were 'not worrying about the risks' of STI/HIV infection. The conclusion was that if these men were irresponsible in their sex lives, they would not be responsible in committing to a PrEP regimen:

'I think if these people are having unprotected sex, they are not worrying about the risks. So, in turn, are not going to worry a bit [about] a pill either.'

(R371, aged 25-30)

Therefore, men who were considered to be irresponsible in one aspect of their lives were also considered irresponsible in other areas and could not be trusted.

II. Age as the *other*

Several other respondents spoke about age in the terms of the *other*. The words 'older' and 'younger' were used by both sets of respondents to identify the other group as risky. However, older men, particularly those aged between forty-one and fifty, were less understanding of younger men's risk-taking. Commenting on a sex party he attended, this seropositive respondent identified 'too many' younger men who were taking risks, suggesting that fewer older men were taking similar risks. This respondent seroconverted over ten years ago and possibly saw his own previous behaviour reflected in the younger men he encountered:

‘There are too many young men, having bareback sex, thinking "it's not going to happen to me".’

(R57, aged 41-50, emphasis respondent’s own)

Commenting on the second part of Juan’s vignette, the following respondent also linked Juan’s behaviour with that of younger men. In the quote that follows, R60 used the word ‘stupid’ in relation to the sexual behaviour of younger men. The choice of word was interesting as it suggested that younger men were lacking in intelligence or common sense in relation to their sexual health. However, further analysis of the respondent’s own sexual behaviour revealed that he had six to ten partners in the last year and sometimes had bareback sex. Yet, it was younger men who he identified as irresponsible for engaging in ‘stupid’ behaviour:

‘fairly typical of a lot of young guys, but highly stupid.’

(R60, aged 41-50)

The following respondent, who was in a long term open relationship with his partner, made an age comparison between his partner’s and his own sexual encounters with other men. R240 stated that his partner took sexual risks with married men who he believed were less likely to be a risk to him. For R240’s partner, married men, who were likely to be older and have less contact with the commercial gay scene, were deemed to be less risky. In comparison, the younger men who the respondent met appeared ‘happy to take more risks’, suggesting they were irresponsible and content to take sexual risks. However, he differentiated between the responsible risks he understands his partner was taking (the responsible risk-taker) and the risks younger men (the irresponsible risk-takers) were willing to take:

‘My partner subscribes to some of the ideas that married men are less likely to be positive and sometimes takes risks in this area. Younger men seem to understand

less about the safe sex message and seem happy to take more risks so I have to take more responsibility for safety.'

(R240, aged 41-50)

This respondent also felt that he had to 'take more responsibility for safety' than his partner. He was obviously concerned for the primary relationship, particularly given that he always had bareback sex with his partner. However, by admitting that he had to take more responsibility for safety, he was also reaffirming his partner's belief that married men were less risky than younger men.

However, younger men also identified risk with older men, although not to the same extent as the respondents who identified younger men's risk-taking. When examining *Anytimebloke's* profile, a small number of respondents identified his age as something that was likely to increase his risk of being seropositive, even though age was not specified on either profile. His age was usually used in combination with other aspects of the profile, but it was interesting to note that these respondents chose to include his age in their assessment of his serostatus. In the quote that follows, a younger respondent referred to *Anytimebloke's* age alongside the observation that he appeared careless:

'Older hairier man, looks careless...'

(R315, aged 18-24)

In the following extract, a younger respondent did not directly identify older men as presenting a risk, but did so indirectly, while commenting on his own sexual experiences with younger men. R383 suggested that it was men outside his own age range that were more likely to be seropositive and therefore more likely to be a risk than younger men. While admitting that he was 'probably naïve', R383 believed that there was little chance of him seroconverting if he chose partners in his own age range:

‘I haven’t even heard of anyone with HIV or having a chance of getting it, I’m probably naïve, but it just doesn’t seem to exist in my age range.’

(R383, aged 18-24)

R383 based his conclusions on the fact that he had not heard of anyone with HIV, or having a chance of acquiring it. While this might be the basis for serosorting, there was a presumption that men will inform him of their serostatus and he miscalculated the risk of younger men seroconverting. This was particularly concerning, as he had never tested for HIV and has had sex with other men while in a ‘monogamous’ relationship. As a result of his actions, it was possible that he could have exposed himself and his primary partner to HIV/STIs.

While it may have been expected that the younger cohort would identify age as a HIV risk, it was also referred to by those aged between thirty-one and forty. In the following quote, R395, a respondent who had sex with other men while in a ‘monogamous’ relationship, identified age alongside the fact that *Anytimebloke* looked like he had a preference for ‘sleazy sex’. Further analysis of R395’s sex life indicated that he had sex with eleven or more men, other than his partner, in the last year. However, he had bareback sex rarely and therefore might have identified himself as responsible. In this case, the *other* were older men and/or those who had sleazy sex:

‘Older guy, looks like he is into sleazy sex.’

(R395, aged 31-40)

As discussed, several younger men identified those who were older as a potential HIV risk, while older men engaged in the same process in relation to younger men. Therefore, each identified the other grouping as irresponsible with the consequences that they, and those in their respective age groups, were less at risk from HIV acquisition.

III. Scene participation as the *other*

As discussed, a large number of respondents identified Juan's use of saunas and sex clubs with the *other*. However, respondents understood that there was a spectrum of the gay scene, where the *others* were overrepresented, such as the facilities used by Juan, while in other parts, respondents deemed the *others* to be less represented. Several respondents who examined the images presented in the mock profiles noted that scene participation increased risk of acquiring HIV. The following respondent linked the clubbing scene with recreational drugs, which he saw as increasing the possibility of sexual risk. The same respondent has previously used various drugs himself, including crystal meth, in combination with both alcohol and other drugs. While currently in a monogamous relationship, he has also previously intentionally sought, and very often engaged in, bareback sex with someone other than a CRP, and has serosorted for partners. Therefore, this respondent indicated a particular awareness of the problem of drug use on some parts of the gay scene and the HIV risk associated with it. It was possible, therefore, that the *others* discussed by R136 were those who were engaging in the type of lifestyle that he had previously engaged in:

'Appears to belong to a clubbing scene where recreational drugs are prevalent and therefore his status may have been compromised.'

(R136, aged 41-50)

However, opinions about scene participation were not uniform throughout. While the previous respondent linked scene participation with drug use and high-risk sexual activity, the following respondent associated similar risks with men who were not on the scene ('in the closet'). From R409's perspective, the gay scene gave men the opportunity to get to know one another - a possibility that did not arise for men in the closet. However, this respondent presumed that men on the gay scene got to know one another prior to engaging in sex and did not partake in cruising to the same extent as men who did not frequent the gay scene. To R409, men that you

knew, through the gay scene, presented less of a risk than the *other* - in this case, men he did not know:

‘Men in the closet seem to take part in more cruising activity and may have sex with more people they don't know.’

(R409, aged 25-30)

It was interesting to note that both R136 and R409 were at the early stages of monogamous relationships (from one to two years); a time when many men take a step back from the gay scene to focus on the primacy of their relationship. In relation to scene participation, the *other* was presented as those who were too integrated, or not integrated enough, in the commercial gay scene. It was therefore those who stood at either end of the spectrum who were identified as a potential risk, as the person who could have acquired and spread HIV. However, single men or men in open relationships, who might be more reliant on the gay scene to source partners, may have had different opinions of the scene than those in the early stages of relationships.

As discussed, there were many ways for men to identify sexual risk in *others*, which was used to minimise the risk attributed to their own sexual activity. In identifying *others* as sexually risky, they might have heightened their own sense of safety and unknowingly put themselves at risk of acquiring HIV while considering themselves as the responsible risk-takers.

Respondents' accounts of their own sexual risk-taking

As previously discussed, even though respondents' behaviours were not significantly different from those they demonised, the creation of various *others* enabled them to minimise the importance of their own risk-taking. However, when respondents spoke of their own risk-taking

behaviours, they often specified that it occurred infrequently or used a number of justifications for their behaviour. Central to these justifications was a lack of control, either in the sexual situation itself, or by external factors that influenced their behaviour, primarily alcohol and drugs. As a result of these justifications, the respondents' previous behaviour was sanitised and his character was not stained in a similar way as the irresponsible *others*.

I. Lack of control – the sexual situation

Some men stated that decisions about condom usage were often dependent on issues such as sexual arousal ('depends on if I'm gagging for it' – R256) and/or the attractiveness of their partners ('depends on how hot he is' – R34). In these situations, men presented themselves as out of control of their own destinies, where desire took over from their own instincts to have safer sex. As R397 pointed out, when he was in lustful situations, nothing else, possibly including his sexual health, mattered:

'All my previous sexual encounters are lustful and spur of the moment. At that time, nothing else in the world matters.'

(R397, aged 25-30)

For these men, their ability to negotiate safer sex was compromised during a heightened state of arousal and/or attraction. Even though many indicated an awareness of the risks they were taking, many felt their desires interfered with their control over the sexual situation and that they did not know how to deal with such a conflict. Speaking about the conflict in the 'I really should say something about condoms...' intervention, a respondent states:

‘I don’t know [how to deal with this conflict] and don’t know where to get help with this. It seems to be the norm.’

(R87, aged 31-40)

This points to the difficulty some men have when attempting to resolve a conflict between their sexual desires and safer sex.

Several receptive respondents also reported that they felt it was more difficult for them to negotiate safer sex due to their position in sex. R78, a mainly bottom seronegative man, who very often had bareback sex with a large number of partners, stated that his condom usage ‘...is an option depending on partner’s preference’ (aged 25-30). It was evident that R78 passed control of condom usage to his partners during sex. One possible explanation for this was a receptive partner’s reluctance to challenge the implicit top role of being in control during sex. In the quotation that follows, R479 explained how he felt less able to assert a desire for safer sex for fear undermining his partner’s dominant active role. His use of the language of domination and submission (‘a hot top has you on a tight lead’) placed the active partner in the dominant role, which implicitly he must not challenge. In addition, R479’s own emphasis on the word ‘stop’ implied that he felt that suggesting condom usage was something that would have abruptly interrupted the flow of the encounter:

‘I always use a condom, but when a hot top has you on a tight lead, when is the best time to say 'stop' without offending or causing offence in the session?’

(R479, aged 41-50, emphasis respondent’s own)

However, it was not only those who placed their sexual encounters in the language of domination/submission, who made such comments. Other receptive respondents repeated

similar sentiments. In the quotation that follows, R484 saw his receptive role as something that should absolve him from responsibility for safer sex:

‘As the bottom guy, I sometimes feel as though it shouldn't be my responsibility to bring up the issue of safe sex.’

(R484, aged 31-40)

It was interesting to note here that R484 might be conflating notions of responsibility and control. As a receptive partner, he alluded to the lack of control he felt he had in the negotiation process, yet used the word ‘responsibility’ to provide a justification for his behaviour. Therefore, it was evident that some receptive men felt that their position in sex meant that they had less responsibility and/or less control to assert a desire for safer sex. This placed these men in a very vulnerable position, particularly as they were at a much higher risk of HIV acquisition than are their active counterparts.

II. Lack of control - alcohol and/or drug consumption

As discussed in the introductory findings chapter, there was widespread use of alcohol and drugs among respondents to the survey, both separately and in combination with one another. However, respondents were also aware of the effect alcohol and drugs had on their decisions. When speaking about condom use, R47, who described himself as a moderate drinker, but has used alcohol in combination with drugs, directly linked his previous behaviour with alcohol:

‘[Condom use] hasn't always happened on one or two drunken occasions.’

(R47, aged 31-40)

This respondent stated that this has happened on ‘one or two’ occasions, emphasising the control he normally has over his behaviour and the infrequency of his non-condom use. Therefore, while he has taken risks when drunk, he has also emphasised that this was not a

regular occurrence and therefore differentiates himself from Juan, whom he described as someone who has made '*very bad* reasoning and decisions' (R47, emphasis my own).

R493, who also described himself as a moderate drinker, but has used alcohol in combination with drugs, stated that he made decisions when he was drunk believing that he had 'thought sensibly about it':

'When sober, [I] have no issue in overriding my base urges. However if drunk, then I would be more likely to take risks, believing that I thought sensibly about it.'

(R493, aged 25-30)

It was clear that R493 understood the lack of control he had over his decisions when influenced by alcohol/drugs. He believed that condom use was sensible in sexual situations and implied that this was something he normally does when sober. This emphasis on his frequent sensible behaviour that R493 engaged in when sober untied his behaviour from that of the irresponsible *other*.

Conclusions

It was evident from these responses that a strong moral discourse around sexual risk-taking was evolving in the MSM communities. Despite being asked to take the role of Juan's friend, a wide range of derogatory terms were used to describe both Juan himself and his behaviour. A number stated that Juan's actions and decisions would lead them to dissolve their friendship with Juan, as maintaining a friendship with someone who took sexual risks could implicate them in such practices. This strong moral viewpoint was repeated by those who related to Juan's reasoning,

even though they were likely to have taken similar risks to Juan. However, many of those who held a moral high-ground *vis-à-vis* Juan's behaviour were also engaging in behaviour that was not dissimilar to Juan's and investing in the creation of an *other* to minimise the importance of their own risk-taking behaviours.

The most common way which respondents contrasted their own behaviour from that of the *other* was by comparing it with those deemed to be more promiscuous and/or more sexually risky than themselves. Respondents benchmarked their own behaviours as responsible against which they measured those they believed to be more promiscuous/sexually risky. However, it became clear that respondents' definition of promiscuity and sexual risk varied according to their own behaviours. Men in monogamous relationships compared themselves more favourably to single men, while those who were single compared themselves to those who were more promiscuous/sexually risky etc. Those who were identified as the *other* were also deemed to be irresponsible in other aspects of their lives and hence, their whole character was stained. It also made it unlikely that those who were *othered* could redeem themselves in the eyes of respondents. This demonization of the sexual *other* made it easier for respondents to characterise themselves more favourably to that *other*, no matter how similar their own sexual behaviours were.

A similar process was used by those who identified age as an *other*. Older respondents identified the behaviour of younger men as irresponsible. In a similar manner, younger men identified older men as the irresponsible *others*. However, those who identified scene participation as an *other* were not in agreement about whom they labelled. Those who were too integrated or not integrated enough, in the commercial gay scene were identified as the *other* who posed a sexual risk to respondents. Therefore, it was those at either end of this spectrum who were deemed to be a greater risk of being an *other*. In the creation of the various *others* identified in this

section, respondents were often sanitising their own previous risk-taking, while actively labelling the *others* as irresponsible.

Respondents to the survey used several justifications for their own previously sexually risky behaviour that was similar to that of the *others*. The first of these was to emphasise the lack of control they had in the sexual situation. Issues around arousal, passion and sexual position were used to justify their behaviours. In these cases, respondents emphasised the reduced control they had when they were aroused or in the receptive position. This was particularly important to receptive respondents who felt they were not in a position to negotiate safer sex, as it would be seen to contradict their implicit receptive sexual role. It was also evident that respondents were aware of the reduced amount of control they had when under the influence of alcohol and/or drugs. Respondents understood that the consumption of alcohol and drugs effected their decisions about condom usage. However, the emphasis on the infrequent nature of their behaviour enabled these men to separate their behaviours from that of the *others* and present themselves as responsible citizens.

The strong moral discourse that emerged from these results revealed the demonization of sexually risky *others* through the use of derogatory terms and opinions. This moral high-ground was maintained even when respondents were engaging in similar behaviours. In the creation of *others*, respondents actively sanitised their own sexual behaviours to minimise the importance of their own sexual risk-taking. As a result, those who were deemed to be the sexually risky *others* were the ones at risk of STI/HIV infection. The consequences of this process was that respondents were not identifying themselves as at risk of STI/HIV acquisition, as they are not identifying their own sexually risky behaviour in the same manner as they did with those they identified as *others*.

Chapter Eight – The Negotiation Process

‘I feel the lines are blurred. What we want to see ourselves as, and what we do...’

(R316, aged 18-24)

Introduction

In this chapter, I discuss various aspects of the negotiation process and the difficulties that arise in each stage of this process. Negotiating risk was an ongoing process for respondents, which was constantly being enacted as a means of filtering out the irresponsible *others*. Seronegative respondents believed that open and honest disclosure of serostatus would allow men to make informed decisions and minimise sexual risk in partner selection. However, non-disclosure of serostatus interrupted this process. While diagnosed seropositive men were fully aware of their serostatus, established HIV stigma in the MSM communities impacted on their decisions to disclose their serostatus to others. In addition, as discussed in the introductory findings chapter, many seronegative respondents were not fully aware of their current serostatus, because they had never tested, had not tested within the last year or had tested, but had never received a test result. Therefore, non-disclosure and/or not having the knowledge of one's serostatus created difficulties for men in the negotiation process. An investigation of disclosure responsibility will take place and the potential misinterpretations will be interrogated. The results indicated that differences in opinions about who was responsible for disclosure led to misunderstandings between seropositive and seronegative men when negotiating sex.

Given the increasing importance of dating websites and phone application in the lives of MSM, an investigation of how respondents understand cues in the online world will take place. This will reveal how respondents read such profiles to identify *others* in order to remove them from potential sexual contact. A number of ways in which men tried to filter out *others* will be discussed and potential misinterpretations highlighted. This filtering process continued when men meet each other in the 'real' world and an examination of how men made allusions to serostatus without direct discussion will be examined. This filtering in the 'real' world might reaffirm what men have understood from their online filtering, or caused them to reassess their

judgements. Therefore, filtering might be a simultaneous, rather than linear process that continues to a point where a decision about condom use/a risk reduction strategy was made. However, in a similar way to reading profiles, the allusions made in the 'real' world also had the potential of being misunderstood by partners leading to confusion.

Following the negotiation process, many men were unsure about whether or not they were about to engage in sex with an irresponsible *other*. In these cases, they might have continued to rely on guesswork or intuition. Therefore, they were left with a choice about using condoms or to engage in risk reduction strategies with a partner who might have been an irresponsible *other*. While some respondents stated a commitment to condom usage, further analysis revealed that many of them had not always used them consistently in the past, or they spoke about their use in a qualified way. When risk reduction strategies were analysed, it was evident that the preferred strategy was serosorting. However, problems arose with this method if all parties were not fully aware of their serostatus prior to engaging in sex. In addition, an exploration of respondent's attitudes to PrEP will take place in order to understand respondents' attitudes towards this risk reduction method before it becomes available on the NHS.

Non-disclosure of serostatus and its impact on the negotiation process

Almost sixty percent of respondents (59%, N: 323) felt that it should not be compulsory for men to reveal their serostatus on public profiles, an issue that was more strongly felt by seropositive respondents, 83% (N: 44) of whom felt that it should not be so. However, disclosure was considered important to many seronegative men as they felt it would allow them to make informed decisions about sex and minimise their exposure to HIV. For most, disclosure was a way for them to make a risk assessment about their potential partner:

‘I think if you’re going to sleep with someone, [you’ve] a right to know the level of risk with that person.’

(R350, aged 18-24)

Many of these respondents did not address the consequences of having this knowledge. However, a number went on to suggest that this knowledge would enable them to reject a partner. For example, R31 felt that informed choices would allow for people to decide ‘whether or not they want to go there’:

‘So [the] other can make an informed decision about whether or not they want to go there.’

(R31, aged 31-40)

Therefore, while disclosure allowed seronegative respondents to make ‘informed’ decisions about sex, rejection of partners was likely to have contributed to the established HIV stigma in the MSM communities.

I. Disclosure and HIV Stigma

It was clear that seropositive respondents, knowing the consequences of seroconversion, had no desire to transmit the virus to other men. In the quotation that follows, R117 compared his attitudes to safer sex before and after seroconversion, highlighting the responsibility he felt about protecting his current sexual partners:

‘Before I contracted HIV, I feel my sexual urges would have overridden logic...Now there is no question [about] using a condom however impaired or aroused I am. I would never want to expose another person to HIV.’

(R117, aged 25-30)

R195 went further by stating that disclosure provided information that allowed for 'sexual intimacy'. While he does not refer to barebacking directly, it was clear that many men made associations between barebacking and intimacy; an intimacy that was not available when they wore condoms. This suggests that R195 was particularly aware of the importance of disclosure when serosorting:

'It is an important piece of information needed to make the decision as to whether one wishes to engage in any kind of sexual intimacy with someone they don't know particularly well.'

(R195, aged 18-24)

However, seropositive men were also keenly aware of the consequences that HIV stigma might have on disclosure. For example, two seropositive respondents used strong one-word responses to describe the reasons why they did not wish to disclose on profiles ('hate' – R182; 'prejudice' – R537), while others emphasised the practical results of enforced disclosure:

'Could lead to discrimination and victimisation.'

(R156, aged 41-50)

Seronegative respondents also showed an understanding of the consequences of HIV stigma. However, many such respondents had friends who were SPDARI:

'Publically displaying HIV status can lead to situations of harassment due to the stigma associated with it.'

(R103, aged 18-24)

While R103 had an understanding of HIV stigma, he also revealed that he was unsure/didn't know if he would have sex with someone who was seropositive. Therefore, it could be suggested

that, while understanding the consequences of HIV stigma, seronegative men might also contribute to such stigma.

II. Disclosure and Responsibility

In relation to responsibility, seropositive men expressed a strong attachment to the idea of mutual responsibility – the notion that everyone has responsibility to protect themselves when engaging in sexual activity. From the perspective of seropositive men, it was not solely their responsibility to protect others, but the responsibility of both parties to protect themselves:

‘it should not be the responsibility of HIV positive men to scream their status from the roof tops, it should be the responsibility [of everyone] to protect themselves, and take responsibility for [their] own health.’

(R75, aged 25-30)

A number of other respondents contextualised their responses in risk narratives and suggested an appropriate stage when it was necessary to disclose. These respondents thought that they should not have to disclose, especially if they engaged in safer sex and/or had an undetectable viral load. They showed an awareness that seropositive men can have sex with seronegative men without putting them at risk, meaning that disclosure was not necessarily required:

‘...if your sexual behaviour does not put others at risk, then it is not really their business what your status is. It’s only if risky behaviour is engaged in that disclosure becomes necessary.’

(R344, aged 41-50)

R71 reiterated the notion of mutual responsibility and disclosure at the point of risky sex, but otherwise felt that disclosure was only important if a question about serostatus was asked. In

doing so, he shifted some responsibility onto seronegative respondents to directly ask about serostatus. Therefore, his idea of mutual responsibility might not always assign equal roles:

‘It is everyone’s responsibility to make their own choices. However, if asked I think it is only right that people are honest, especially if BB [bareback sex] is on the agenda. I would never BB without the other person knowing my [seropositive] status.’

(R71, aged 41-50)

While seropositive respondents showed a degree of responsibility in their decisions about disclosure, it should be kept in mind that laws around HIV transmission may have played a role in their discussions. The following respondent considered when it was appropriate to disclose, but also raised the issue of the HIV transmission laws:

‘It is down to the person as a responsible individual to disclose their status when they feel the other person would benefit from knowing, or if the other person insists on doing something potentially unsafe. Obviously, it is illegal to sleep with someone unprotected if you know you have HIV so there is that part of the argument too to say it should be visible.’

(R117, aged 25-30)

Given that this respondent raised the issue of the HIV transmission laws (the survey itself did not address these laws), it was possible that knowledge of these laws might have also influenced the responses of other seropositive respondents. Nevertheless, it was clear that the majority of seropositive respondents felt that disclosure would contribute to HIV stigma in the communities or that both partners were equally responsible for the sex they were engaging in.

However, the issue of mutual responsibility raised by the seropositive respondents above was not one shared by most seronegative respondents. Many assumed that sexual partners were of the same serostatus, or that they would be informed in the event of a partner being seropositive. This assumption could have placed these men at risk of acquiring HIV, particularly if seropositive men adhered to their own particular notion of mutual responsibility:

‘...however until a person states they are [seropositive], I’d assume them not to be.

I’d hope people would be responsible enough to share the information that they are positive if they were potentially putting others at risk.’

(R394, aged 31-40)

This respondent used the word ‘responsible’ in relation to seropositive men - a word repeated by most seronegative men in their responses about disclosure. The use of this word suggests that there was a clear division in the minds of seronegative men about those seropositive men who were responsible (disclosure) and those who were irresponsible (non-disclosure). However, it was evident that these respondents also felt that the responsibility for disclosure firmly lay with seropositive men and that it should not be left to seronegative men to enquire or ask:

‘They shouldn’t need to broadcast it to the world if they don’t want to but then they do have a responsibility to tell potential partners.’

(R47, aged 31-40)

A similar theme about disclosure was taken up by the following respondent, but he made interesting use of a legalistic comparison. For R43, the seropositive partner was ‘guilty’ for non-disclosure, while the seronegative partner was ‘innocent’. The use of the word ‘innocent’ here was interesting as it established the seronegative partner as a victim without responsibility for protecting themselves:

'I believe I think everyone is HIV negative unless told otherwise (maybe such as innocent until proved guilty).'

(R43, aged 31-40)

The belief held by seronegative men that it was the (seropositive) individual who was responsible for disclosure contradicted the principle of mutual responsibility asserted by many seropositive men. While many seronegative men might wait for disclosure, seropositive men were expecting others to take responsibility for their own health and for establishing the serostatus of a potential partner. If both believed that the other side was doing as expected, potential misunderstandings were likely to arise, particularly when men were serosorting for partners.

Among those who felt that it was the responsibility of seropositive men to disclose their serostatus, a number felt there was an appropriate stage for such disclosure. Nevertheless, not all men agreed about when it is most appropriate for disclosure to occur. Some felt that it 'should be before meeting in real life' (R242, aged 18-24), referencing the use of the internet for identifying potential partners. Importantly, this is a stage that can be measured precisely by both partners. However, not all men were so clear. For example, R442 thought that disclosure was not necessary until they 'become partners in a relationship' (R442, aged 31-40). The difficulty with this response is that the beginning of a relationship is not always precise and may be open to interpretation. Many people have different understandings of where a relationship begins and while one partner may assume that they are in a relationship, the other may not always be in agreement with this.

Other respondents felt that the appropriate stage for disclosure was before sexual activity. In the quotation that follows, R19 stated that seropositive men will disclose before sex 'if they're responsible':

'It's [serostatus] personal and if they're responsible they'll disclose it before sex.'

(R19, aged 18-24)

However, in a similar manner to the discussion about a relationship, 'sex' was open to interpretation. For example, for some, disclosure might be important at the stage of kissing, for others, at the point of oral sex, anal sex, bareback sex etc. While discussing why he was unsure about having sex with a seropositive partner, the following respondent pointed to difficulty with the definition of 'sex':

'It would depend on your definition of sex. I would have non-penetrative sex with them [seropositive men], but not penetrative sex.'

(R5, aged 25-30)

Therefore, while R19 may have a clear idea about when disclosure was necessary; it might be unclear to others. In addition, as already discussed (see R344 above), seropositive men were aware that they could engage in sex with seronegative men, where the risk of HIV transmission was significantly reduced. Therefore, it was possible that seropositive men had a different understanding of the necessary point of disclosure to their seronegative counterparts.

The non-verbal nature of the negotiation process

As discussed, moral judgements made by seronegative men might have encouraged seropositive men not to disclose their serostatus to others. Given that both seropositive and seronegative men understood the effect of these moral judgements in the form of HIV stigma, it was perhaps

no surprise that negotiation of sex was not always verbal in nature. This was particularly true in public sex environments, such as saunas, cruising locations etc., which were not always conducive to verbal communication. As R508, a seropositive man in an open relationship, pointed out:

‘As a cruising gay man, I often think about the risks involved in casual sex. Given the anonymity and promiscuity of the individuals that I have sex with I do not feel in a position to discuss safe sex prior to intercourse.’

(R508, aged 31-40)

The respondent understood that there was a code of silence that was inherent in the environments he used and therefore discussion of safer sex was not an option, even though he was aware of the risks he was taking. Given that this respondent was already seropositive and in an open relationship, it was unclear if the risk he discussed concerns his own risk of STI acquisition, or the risks he posed to other men and/or his primary partner. However, as he had an undetectable viral load, the risk he posed to other men was significantly reduced. Nevertheless, this code of silence, which was prevalent in such environments, took precedence over any verbal negotiation of safer sex.

However, it was not only in public sex environments that men found it difficult to talk about safer sex and risk. Respondents were aware that this type of discussion with potential partners had consequences for sexual desire in an encounter. In the quote that follows, R539 spoke about the consequences about thinking (internal) and talking (external) about risk. Therefore, the consequences were twofold, one for himself and another for his partner when his concerns were verbally expressed:

‘Probably end up ‘ruining’ the moment by thinking and talking about risk...causing desire to evaporate!’

(R539, aged 51-60, emphasis respondent’s own)

Interestingly, R539 placed emphasis on two of the central words in the quotation by putting *ruining* in inverted commas and by placing an exclamation mark after *evaporate*. The two central points for him were that he could ruin the encounter and cause the desire to evaporate. Therefore, the consequences for discussing safer sex/risk might increase men’s desire to engage in non-verbal negotiation with partners.

I. Filtering in the online world - Understanding cues from profiles

There were many ways men could identify the irresponsible *other* to exclude them from sexual contact. Given the popularity of internet sites and phone applications in the MSM communities as an initial point of contact with potential partners, profiles were often used as a means to indicate and/or understand serostatus prior to meeting. Many such sites/apps do not allow for a person to specify their serostatus in their drop down menus, although there are open text boxes in which men can reveal and/or give more details about their preferences. However, as previously discussed, the prevalence of moral judgements in the communities meant that seropositive men were unlikely to choose such this option. In order to try to understand this phenomenon, respondents were presented with two mock profiles³³ and asked to identify the serostatus of the men in the profiles and explain the reasons why they came to this conclusion.

Possibly, from experience, respondents were aware that not all of the information presented on profiles was accurate. As R9 pointed out, ‘these profiles are full of lies and distortions’ (aged 41-

³³ These two profiles, *Hungasahorse* and *Anytimebloke* are available in Appendix Two.

50). However, while respondents understood that inaccuracies were often presented on profiles, they were also aware that they could be used as a means to garner information about the individual's serostatus. While admitting that there were inaccuracies in profiles, R35 stated that people can search for 'clues' on profiles about their potential partners:

'People need to be able to look for clues and not have everything spelt [spelled] out. Plus, you can put anything on the internet, it can be true, it can be false, you never know.'

(R35, aged 41-50)

These men revealed a keen awareness of the lies men told on such profiles. Some respondents admitted that they had presented themselves inaccurately on profile suggesting that this was a 'norm' on such profiles. Even though there was an awareness of the presence of untruths, there was also an understanding that profiles were also used to garner certain information about potential partners.

The following is a discussion of the most common means of interpreting serostatus from profiles. Respondents often used a variety of means, but the term 'safer sex only', emphasising sex over a relationship and sexual role were the most common ways for respondents to understand serostatus from the mock profiles presented to them. However, respondents often used a variety of indicators to come to conclusions about serostatus, revealing the complexity of such interpretations.

a) 'Safer Sex Only'

It was clear from the responses to both profiles that there was an over-reliance on the term 'safer sex only' for interpreting serostatus on profiles. While serostatus was not revealed on either profile, the appearance or non-appearance of this term on was used by the majority of

respondents to indicate a serostatus. *Hungasahorse*'s profile specified a preference for 'safer sex only' and most respondents used this to justify why they thought he was seronegative:

'This person refers to 'safer sex only', which to me implies that they are conscious of their sexual health, hence not wanting to contract anything.'

(R215, aged 18-24)

For others, the 'safer sex only' term raised questions when they realised the term could be interpreted in different ways to imply either serostatus. Still, despite this confusion, R492 opted for identifying *Hungasahorse* as seronegative:

'He discloses that he likes safer sex. That doesn't mean he always has safer sex. He could possibly prefer safer sex because he himself is HIV-positive and wishes not to spread the virus, but I'll play along and say that I think of him as being HIV-negative.'

(R492, aged 25-30)

Others highlighted the difference between 'safe' and 'safer' sex, with the latter raising questions about serostatus. In the quotation that follows, R455 pointed to the difference he found between the two words. He implied that 'safe sex' was a guarantee of protection, while 'safer sex' was not:

'saf-ER sex is no guarantee.'

(R455, aged 41-50, emphasis respondent's own)

The omission of the 'safer sex only' term also played a role in respondents' interpretation of *Anytimebloke* as seropositive. This indicates the centrality of the term 'safer sex only' for respondents when they tried to decode serostatus from the profiles. The fact that the omission of this term was noticed by respondents serves to highlight their reliance on this term as a clue to understanding serostatus:

‘In comparison to the last advert [*Hungasahorse*], this guy seems more likely to be positive because he does not specify 'safer-sex only'.'

(R24, aged 31-40)

It was clear, therefore, that ‘safer sex only’ played a very important role in how respondents understood serostatus from profiles. While its presence was seen to indicate seronegativity, its omission was interpreted by many respondents as an indicator of seropositivity. However, the term also appeared alongside many other mechanisms related to understanding serostatus. Therefore, it was likely to be used in combination with other factors in order to identify a potential partner’s serostatus.

b) Emphasis on sex or relationship

In his profile, *Hungasahorse* explicitly expressed a desire for a relationship and this was used as a justification by many respondents for assuming that he was seronegative. In the quote that follows, R239 combined ‘safer sex only’ with the fact that *Hungasahorse* was looking for a relationship as reasons why he believed that *Hungasahorse* was seronegative. However, being aware of the inaccuracies presented on profile, R239 also questioned if it was *Hungasahorse*’s intention to mislead him into making him believe that he was seronegative:

‘I feel the fact he is looking for 1-on-1 [sex], potentially a relationship and explicitly states safer sex only – gives me the impression he is careful. However – that may be the intention. I would be more likely to say negative in this instance however.’

(R239, aged 18–24)

Although *Anytimebloke* also stated that he was also looking for a relationship and 1-on-1 sex, most respondents identified his fetish for saunas and his desire for group sex, as something which would lead them to believe he was seropositive:

‘All signs points to HIV positive. This person is only after one on one sex, frequents saunas and all the places HIV is said to be contracted the most on average. He is also into things like group sex etc.’

(R314, aged 18-24)

R246 gave a more detailed response about *Anytimebloke’s* profile in which he discussed *Anytimebloke’s* emphasis on casual sex over other forms of sex. Even though R246 acknowledged *Anytimebloke’s* desire for a relationship and 1-on-1 sex, he felt that his interest in group sex took precedence when deciding serostatus:

‘...despite him listing he wants a relationship and friends or just 1-on-1 sex, he seems casual about sex by stating he wants group sex... [and] there is a chance he could have HIV.’

(R246, aged 18-24)

Interestingly, R431 expressed surprise that *Anytimebloke* had ‘openly’ admitted to liking saunas and group sex in his profile. There was an implication here that one should not openly admit such preferences on their profiles, even they engage in such activities:

‘For someone to openly admit groups and saunas suggest they are risky when it comes to sex, so I would assume they were positive.’

(R431, aged 25-30)

It was evident therefore that expressing a stronger desire for a relationship or sex in a profile influenced respondents’ perception of serostatus. Those who expressed a desire for a relationship were seen as being seronegative, while those who articulated a stronger interest in sex (whether or not they stated an interest in a relationship) were seen as being seropositive.

c) Sexual Role

A number of respondents identified sexual role as influencing serostatus. These respondents showed an understanding of how sexual role influences HIV risk. For example, R483 cited *Hungasahorse's* sexual role (top-only) as something that influenced his decision to view him as seronegative:

'...He is also exclusively top, which places him statistically at somewhat lower risk of HIV infection.'

(R483, aged 31-40)

On the other hand, a number of respondents also used *Anytimebloke's* sexual role (versatile) to identify him as seropositive. In the quote that follows, R199 used strong moral terms to identify *Anytimebloke's* versatility as something that increases his risk of HIV acquisition:

'Definitely positive. He's a sauna slut. The versatile bit makes him more likely to catch something too because he's more open to being top or bottom, which expands his potential partners who may be top only, bottom only or also versatile.'

(R199, aged 18-24)

Further analysis revealed that R199 identified himself as versatile, which is somewhat paradoxical given his account of *Anytimebloke*. However, R199 had been in a committed relationship for the last year, so it was possible that his view of single men had changed from when he himself was single. However, it was clear from these quotes that these respondents had knowledge of how sexual role impacted upon serostatus and that they used this knowledge to assess the likelihood of someone being seropositive or seronegative.

d) Lesser used cues

A number of other cues were used by respondents to understand serostatus, but to a lesser extent. The lesser used cues most commonly referred to by respondents were appearance, bisexuality and usernames.

- Appearance

Some respondents went on the appearance or 'look' of the men in the images. While one respondent simply stated that *Anytimebloke* 'looks like a breeder' (R410, aged 25-30), another gave more detail about *Hungasahorse*:

'The image suggests he might lead a more promiscuous lifestyle and more vulnerable to contracting HIV.'

(R482, aged 41-50)

Those who identified serostatus in this way were more likely identify the profile as seropositive. In these cases, the primary focus was on 'looks' and other information provided by *Hungasahorse* or *Anytimebloke* was generally ignored. This suggests that decisions based on appearance were made quickly and determined without further information from the profile.

- Bisexuality

Hungasahorse's bisexuality was also noted by a number of respondents. However, his bisexuality was interpreted inversely by different respondents. For example, R22 reasoned that because women are statistically less likely to acquire HIV, then *Hungasahorse* was also likely to be seronegative:

'Bisexual (so some or all of his sexual experience could be with women, who are least likely statistically to have HIV/AIDS).'

(R22, aged 31-40)

However, *Hungasahorse*'s bisexuality was also used to identify him as seropositive by other respondents. For these respondents, bisexuality implied promiscuity and increased the likelihood of HIV risk:

'...he states to be Bi, which means he could be fucking anyone generally.'

(R551, aged 41-50)

It was evident that bisexuality implied different serostatuses to different respondents. While some felt that bisexual men had less exposure to HIV, others placed emphasis on promiscuity and increased HIV risk. Therefore, the cue of bisexuality was equally likely to indicate seropositivity as it was to imply seronegativity.

- [Usernames](#)

A number of respondents identified usernames as an indicator of serostatus. Interestingly, the vast majority of respondents who mentioned usernames focussed on *Anytimebloke*'s username rather than *Hungasahorse*'s, even though each had a sexual focus. This may have been because they found it easier to identify *Hungasahorse* because of the term 'safer sex only' and had to look more deeply for cues about *Anytimebloke*, or that they found *Anytimebloke*'s username to be more sexually active than *Hungasahorse*:

'Possibly positive. The profile name suggests a high sex drive and possibly that he's less discriminating in choice of partners (having sex is more important than who, how, where and so on)...

(R344, aged 41-50)

However, usernames were continually used in combination with other cues from profiles, suggesting that it was not deemed as important to respondents as other cues. However, when used in combination with other cues, it strengthened their beliefs about the serostatus of profile.

However, cues were often used in combination with one another, with some cues prioritised over others, highlighting the complexity of the reasoning processes involved. For example, R421 combined a wide variety of cues to come to the conclusion that *Hungasahorse* was seronegative:

‘Impossible to be sure but 1) indicates "safe sex only" which suggests HIV negative to me (though not absolutely) 2) indicates interest in a relationship which would tend towards negative status in my gut feeling 3) bisexual indicates either both active in gay and straight communities (and that to me suggests less promiscuity though on reflection that doesn't make sense), or could be that "bisexual" was chosen due to the person's feelings of stigma from being seen as only gay. Very little else on the profile I think is relevant as I imagine it has come from a drop down selection menu. However the profile name suggests a focus on sexual encounters that would make me think they were higher risk of HIV. Overall I seem to put a great deal on the "safer sex only" statement but on further reflection (beyond gut feeling) I see that person as higher risk.’

(R421, aged 41-50, single)

The complexity of R421’s thinking revealed the intricacy of some respondent’s decision making. While he initially identified some of the cues as being associated with a particular serostatus, he also reflected back and considered other meanings of certain terms. Therefore, it was likely that respondents considered a wide variety of meanings and understandings of terms before making a decision about serostatus. It is possible that, like ‘bisexuality’ discussed above, individuals had different understandings of the same terms or prioritised one particular understanding given the other information obtained from the profile.

II. Filtering in the 'real' world - Allusions to serostatus

Given that negotiation of safer sex may occur in a non-verbal manner, respondents were asked if they had made suggestions about, or alluded to their own serostatus without a direct discussion³⁴. Over seventy percent of respondents (72.2%, N: 398) stated they did not make such allusions. This does not necessarily imply that these respondents always discussed their serostatus, but that they believed they were not alluding to their serostatus, which may, or may not, have been the case. Indeed, they might have felt that it was unnecessary to discuss serostatus given the type of sex they intended to engage in, or if they believed their partner was of the same serostatus. However, a further 26.7% (N: 147) stated they have made such allusions. Further analysis of this group showed that allusions were most common in the 41-50 age group (29.9%, N: 44) and seropositive men were far more likely to use allusions (63.6%, N: 35) than their seronegative counterparts (25.6%, N: 99). When asked to explain why they found it difficult to discuss their serostatus, both seropositive and seronegative respondents generally referred to HIV stigma as the primary reason.

Those who stated that they allude to their serostatus were asked which mechanisms they used to indicate their serostatus. The most commonly used mechanism was to state on their profile that they have safer sex all the time (54.9%, N: 78) followed by the dropping of hints (33.1%, N: 47) and leaving condoms around in tacit preparation for sex (31%, N: 44). Several other responses proved less popular, including engaging in sex associated with a particular serostatus (14.8%, N: 21) and telling partners that there was no need for a condom with them (13.4%, N: 19). Eighteen respondents (12.7%) opted for other responses, which included a variety of

³⁴ Respondents were given the following information to help them understand the question more fully: 'Many men, whether positive or negative, find it difficult to openly discuss HIV with their potential partners. Instead, they allude to, make suggestions about, or try to indicate their HIV status to other men. For example, many men state on their profiles that they have 'safer sex only' as a way of indicating their HIV status.'

normative cues, such as expressing a like/dislike of bareback sex, using terms such as 'DDF'³⁵, 'clean'³⁶, or having a biohazard tattoo³⁷. A similar normative cue was used by R86 when he spoke of bareback parties:

'At a bareback group sex party, it's assumed guys have HIV'

(R86, aged 41-50, seropositive)

However, the difficulty with normative cues is that the contained assumption is not always shared by all those involved. If someone misinterprets these cues, they might place themselves at risk without understanding that risk.

As respondents could opt for more than one mechanism, it is possible that a number of mechanisms were used at the same time. For example, R344 engaged in a number of mechanisms to suggest to others that he is seropositive, which points to the complexities of some men's allusions. However, R344 was not only alluding to his own serostatus, but also 'fishing' for this partner's. In doing so, he was engaging in a two-way process of investigation, which not only involved him suggesting, but also encouraging partners to disclose and/or reflect upon whether or not safer sex was necessary:

'Talk about the risks of unprotected sex. Talk about HIV and STIs, showing an in depth knowledge of the issues. Both strategies are hinting at my status and also fishing for information about theirs. Engage in sexual behaviour that hints at a desire to have unprotected sex, but stop at actually engaging in it. This often prompts the other person to say that they do/don't like bareback sex and at this

³⁵ DDF: Drug and disease free

³⁶ Clean: a term which implies seronegativity. It is a controversial term resisted by many within the MSM communities, as it implies that seropositive men are unclean/dirty.

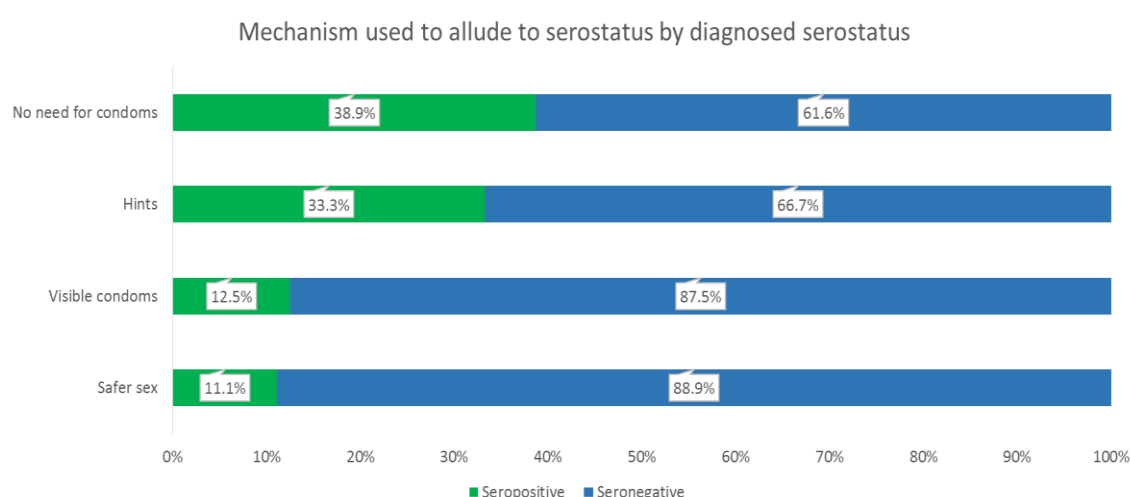
³⁷ Biohazard tattoos are commonly used to indicate toxicity i.e. a positive serostatus.

point there seems to be more of a tendency for them to think about the consequences and discuss the issue of status - often without directly asking mine, but establishing whether or not it is wise to use protection.'

(R344, aged 41-50, single)

However further analysis of the stated allusions revealed that both seropositive and seronegative men used the same allusions to indicate their different serostatuses, which might have led to misunderstandings between both groups. For example, of those who used 'there's no need for condoms with me' as an allusion, 38.9% (N: 7) were seropositive, while the remainder were seronegative. One third of respondents (N: 14) who stated that they 'drop hints for him to pick up on' were seropositive. Given the prevalence of 'the use of the term safer sex only' on profiles, it remained far more popular with seronegative respondents (88.9%, N: 64) than with those who were seropositive (11.1%, N: 8). Nevertheless, given the consequences of possible misunderstandings, it remains an important issue that needs to be addressed.

Figure 8.1: Mechanism used to allude to serostatus by diagnosed serostatus.



Outcomes of the negotiation process

One of the effects of the shifting moral discourse discussed in the previous chapter was that men were more likely to use condoms or risk reduction strategies with men they deemed to be an irresponsible *other*. The negotiation process discussed above gives us an indication of how respondents used a variety of techniques to understand if an *other* was a risk to them. However the negotiation process was an on-going one and decisions were often based on intuition ('all I can do is take a calculated risk using my intuition' – R26) or guesswork ('consider the risk associated with the situation and make an educated guess' – R121). However, there was also an awareness that mistakes could be made in this process. For example, R161 made it clear that while he does what he wants to do, he made these risk assessments hoping 'for the best':

'I do what I want to do, I do a risk assessment in my head and hope for the best.'

(R161, aged 18-24)

Therefore, it was likely that the negotiations process was assessed and reassessed up to the point of a decision being made. However, respondents had a distinct decision to make when having sex with other men who may be an irresponsible *other*; the use of condoms or engaging in at least one risk reduction strategies.

I. Condom Usage

It was clear from the responses to the survey that a number of respondents were committed to condom usage, even when they found themselves in challenging situations with other men. When asked how they would deal with a discussion about condoms when aroused, many of these respondents gave similar responses to that of R514:

‘Safer sex would always take a priority.’

(R514, aged 25-30)

However, very few of these men went on to give details about how they would enact safety in these situations. Of those who did, their primary solution was to physically remove themselves from the situation (e.g. by going to the bathroom or leaving a club etc.), although how likely there were to do this in reality is questionable. While many respondents asserted that they would use condoms if they found themselves in an imagined dilemma, further analysis revealed that most of these respondents had previously engaged in bareback sex, although many had done so ‘rarely’. This suggests that while these men made comments that suggested that they are wholly committed to condom use, this was not always reflected in their previous behaviours. Other respondents stated that they would want to have safer sex, but not in a categorical way. These respondents were inclined to use words such as ‘try’ or ‘probably’, which suggests they were uncertain of how they would resolve such a dilemma. Therefore, while these men asserted a commitment to condom usage, they often admitted difficulty with maintaining this commitment at all times.

However, commitment to condom usage was dependent on condom availability. Almost half of respondents (46.9%, N: 259) stated that there has been an occasion when they have not used a condom because they were unable to access them at the time. There could have been for a number of reasons. For example, although there is wide availability of condoms on the commercial gay scene, it is possible that men are not aware of their location in particular venues, or too embarrassed to remove some. If men do not access the gay scene, they must actively seek and carry condoms. However, carrying condoms may cause embarrassment for some men, as they may be seen by others at inappropriate times. As a result, some men might only carry condoms if they have an intention to have sex. As R436 pointed out:

‘I find I never prepare when going out, as I don’t go to meet someone for sex. It always randomly happened, so if condoms are available they will be used; if not, and it goes too far, I would go ahead without.’

(R436, aged 25-30)

This does not necessarily imply that all respondents had unsafe sex when condoms were unavailable, as some might have adjusted their sexual practices (e.g. only having oral sex) to suit their unavailability.

II. Risk Reduction Strategies

However, if respondents were uncertain about the *other’s* serostatus after the negotiation process, they could employ a number of risk reduction strategies to minimise their HIV risk. Key to engaging in these strategies was that men understand they were at risk. If they did not understand their risk or did not see the *other* as a risk, they were unlikely to engage in such strategies. The 407 respondents who admitted to having bareback sex with someone other than a CRP were asked whether or not they had employed any risk reduction strategy while engaging in barebacking. A number of different primarily closed questions about individual strategies were included in the survey.

a) Viral-sorting

Viral-sorting was perhaps the most sophisticated, but least-commonly used, risk reduction strategy available to seronegative MSM. It required detailed understanding of viral loads and the consequences these have for risk reduction. It also necessitated that the serosorter be open to having sex with someone they know to be seropositive. Those who have had, or would consider having, sex with seropositive men were asked if they had deliberately sought a seropositive partner who had an undetectable viral load. Of those, only thirteen respondents

who had engaged in bareback sex (6.6%) stated that they had done so. However, eleven of these thirteen respondents had intentionally sought bareback sex, accounting for 19% of this grouping. While more accepted as a risk reduction strategy by those who had intentionally sought bareback sex from someone other than a CRP, these results suggested that viral-sorting was relatively unpractised.

b) Withdrawal

The results indicated that withdrawal was used by a minority of seronegative barebackers, with only 11.8% (N: 41) stating that they always withdrew before ejaculation. A further 17.1% (N: 59) said they never withdrew, while the remainder used withdrawal inconsistently. Withdrawal was even more unpopular with men who intentionally sought bareback sex, with only 5.6% (N: 6) stating they always withdrew and a further 25.9% (N: 28) that they never withdrew. Further analysis of this variable showed no significant relationships with a number of other variables such as age, sex role, relationship status, serostatus etc.

c) Strategic Positioning

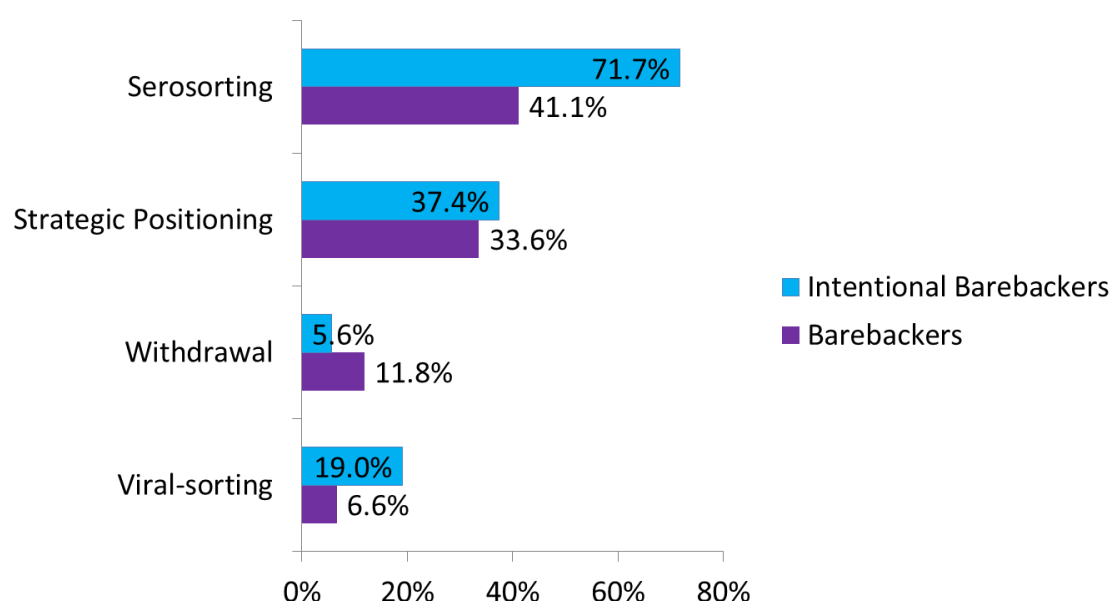
Strategic positioning is a risk reduction strategy that involves a man choosing to take a top/active role in barebacking to minimise risk of acquiring HIV. When those who identified as active in anal sex were removed from the analysis (as they cannot chose to change their role), just over a third of seronegative respondents (33.6%, N: 97) stated they had used strategic positioning as a risk reduction strategy. As one would expect, the more closely someone identified with the bottom role, the less likely he was to utilise strategic positioning as a risk reduction strategy. Those who had intentionally sought bareback from someone other than a CRP were only slightly more likely to use strategic positioning (38.5%, N: 35) as a risk reduction strategy than those who had not. Seropositive respondents were slightly less likely to utilise strategic positioning (29.2%, N: 14) than their seronegative counterparts.

d) Serosorting

The most commonly used risk reduction strategy used by seronegative respondents who had engaged in bareback sex was serosorting, with over four in every ten of these respondents (41.1%, N: 163) stating that they had chosen a partner of the same serostatus for barebacking. However, serosorting was far more common among those who had intentionally sought bareback sex, with almost three-quarters of these respondents (71.7%, N: 76) stating that they had serosorted for partners. This suggests that those who were intentionally seeking bareback sex were more likely to understand that they were engaging in risky behaviour and that this knowledge allowed them to take steps to reduce HIV transmission. A similar percentage of seropositive respondents (70%, N: 35) had also engaged in serosorting.

Awareness, and effective communication, of serostatus are keys to successful serosorting. However, further analysis showed that a significant number of serosorters were not fully aware of their serostatus. For example, twenty-one respondents who had serosorted (12.9%) had never tested for HIV and/or any STIs and a further four (2.5%) had never received a HIV test result. Of the remaining men who had received a HIV test result, over a fifth (23.3%, N: 38) had not tested within the last year. However, 21.8% (N: 35) of serosorters were testing every three months. These results suggests that, while almost one in five seronegative serosorters made an effort to be aware of their serostatus by testing once every three months, almost four in every ten (38.6%, N: 63) were likely to have been unaware of their serostatus when serosorting for partners. This points to the ineffectiveness of serosorting as a risk reduction strategy.

Figure 8.2: Risk Reduction Strategies used by Seronegative Barebackers



e) PrEP as a potential risk reduction strategy

All seronegative respondents to the survey were asked a number of questions about PrEP as a risk reduction strategy, whether or not they had previously engaged in barebacking. PrEP was on trial in the UK during the course of the survey, but has yet to be made widely available. Almost forty-five percent of respondents (43.9%, N: 218) were aware of the PrEP trials³⁸, indicating good knowledge of a medical treatment that could affect them in the future. In order to allow respondents who were not familiar with PrEP to answer further questions, a more detailed definition³⁹ was provided on the page after this initial question in order to enable them to answer further questions about PrEP.

³⁸ Respondents were initially asked if they had 'heard of the PrEP trial whereby people who are HIV-negative take HIV medication (also known as antiretrovirals) to keep them from getting HIV'.

³⁹ 'Currently on trial in the UK, PrEP is HIV medication that is taken by negative people in order to prevent them from acquiring HIV. It is different from PEP (post-exposure prophylaxis) in that the drugs are taken *before* potential exposure to HIV. In order for PrEP to be effective, it must be taken consistently and have a number of potential side effects. PrEP is intended to be taken over the short term with people coming off it when they believe that they are at a lower risk of HIV.'

Respondents were then asked to agree or disagree with a few statements about PrEP. From the results presented in the table below, it was evident that the majority of respondents thought that PrEP would increase other STIs and options for men who did not use condoms, while also making seronegative men reliant on HIV medication, but decreasing the number of new HIV infections. However, given the effectiveness of PrEP in decreasing the numbers of new HIV infections in the trials, the percentage of agreement with PrEP's ability to reduce new HIV infections remained quite low.

Table 8.1: Percentage agreement with statements that PrEP will...

PrEP will...?	Percentage	Number
Increase other STIs	65.7%	327
Increase options for men who don't use condoms	62.3%	307
Make negative men more reliant on HIV medications	59.2%	292
Decrease the number of new HIV infections	51.5%	257
Make barebacking more acceptable	49.8%	246
Increase intimacy during sex	28.2%	140
Make you more relaxed during sex	22.7%	112
Make sex more pleasurable	20.5%	102

However, when asked if they thought seronegative men would take PrEP if it became available, respondents were more positive. Almost half of the respondents felt that they were likely to take PrEP (48.3%, N: 240), while only 18.9% (N: 94) thought they would not. The remaining 29.3% (163) were unsure whether men would take the drug. These results suggest that while

respondents held largely negative opinions about PrEP, as seen in the table above, respondents were more positive about the possibility of seronegative men taking the drug if it becomes more widely available in the future.

When asked to discuss their opinions about PrEP, several respondents considered this to be a positive progression in the fight against HIV. For example, some respondents felt that PrEP would be an additional protection for them to use. Like R411 below, many described PrEP as a form of 'extra protection', although it was not clear whether PrEP would be used in addition to condom usage or for serosorting:

'I believe that if something becomes available to people that is viewed as extra
'protection', then it would probably become popular.'

(R411, aged 25-30)

Those who spoke more directly about condom usage in the context of PrEP usually did so by implying that they would reduce or abandon their use. For example, R367 who was in a 'monogamous' relationship, but often has bareback sex with other men, states:

'I would take them. I would definitely use condoms less.'

(R367, aged 25-30)

While this quote may lead us to believe that those who are deceitful to their partners might be more optimistic about other men using PrEP, the opposite was the case. Men in open or deceitful 'monogamous' relationships were slightly less optimistic about PrEP usage than others.

Pleasure and intimacy were also discussed by respondents who thought that men would be likely to use PrEP. These respondents showed an awareness of the effects of condom usage on

their sex lives. While he sought to be ‘completely’ safe, R379, who provides little biographical information, stated that:

‘People want to be completely safe, whilst they enjoy the extra sensitivity given by no condom.’

(R379)

However, while being optimistic about PrEP, other respondents raised concerns about men’s ability to commit to the treatment regimen involved. For example, R254 felt that, despite the benefits of PrEP, the treatment regimen⁴⁰ would be too difficult for men to manage:

‘I think people would see it as a good idea, but as it must be taken consistently, people will see it as too arduous a task to undertake despite the protection it provides.’

(R254, aged 18-24)

This suggests that while these respondents held primarily positive views of PrEP, there were concerns about whether or not men would be able to commit to the treatment regimen.

Other respondents felt that PrEP would primarily be of benefit to those in serodiscordant relationships. It was clear that these respondents felt that being in such relationships posed the highest risk for the seronegative partners and therefore PrEP was necessary:

‘In the case of someone having a positive partner, I can see them taking the medication, but otherwise I am not sure generally [if] others would be so proactive.’

(R462, aged 41-50)

⁴⁰ The definition of PrEP given to respondents reflected the PROUD study that was being carried out in England at the time of survey construction. Providing information about the on-demand trial (IPERGAY) that was being studied in France and Canada was likely to confuse respondents and therefore this example was omitted.

However, other respondents who spoke about seropositive men discussed avoiding them as a means of risk reduction. These respondents saw avoidance of seropositive men as a more effective way to reduce their risk of HIV acquisition than taking PrEP. R517, who has never tested for HIV and has had sex with a large number of men while in a 'monogamous' relationship stated that:

'Not having sex with positive men and using condoms would be more effective and with no side effects.'

(R517, aged 25-30)

The presumption in R517's response was that he would be told, or he would be able to find out, if a potential partner was seropositive. His belief that he can understand serostatus outweighs any perceived benefit from PrEP. A similar response was given by R466, who reasoned that the chances of 'most people' acquiring HIV was so low that it would affect men's commitment to the treatment regime:

'Given the overwhelming majority of gay men don't have HIV, and those most people know most of the time the risk isn't even theoretical, the likelihood they'll follow the necessary instructions closely enough to make it [PrEP] work is extremely low.'

(R466, aged 25-30)

Even though he saw his HIV risk as low enough not to be theoretical, R466 was mainly bottom and reported regularly having protected sex with other men in the last year. Given that R466 regularly practiced safer sex with his partners, it was likely that he believed his risk to be far greater than what he was suggesting in the above quotation.

However, the small number of respondents who sought to be included in the PrEP trial often reflected deeply on their sex lives and the impact the drug could have on them. In the following quotation, R60 described how he sought access to the PrEP trial, but was denied because it was not available in his area at the time:

‘I guess if I told [yo]u I asked to be considered for any PrEP trial in [local area], that would sum me up. The nurses in the GUM clinic at the [name of hospital] know me well – I am fun and outgoing and 110% honest and they know they can ask me anything and I will be truthful. I think I am typical of many guys. I fear HIV. My ex who lives with me is poz [seropositive]. He copes WAY better than I think I would and yet, I still take risks...I get checked every three months, more if I go on holiday (one before I go; one after).’

(R60, aged 41-50, emphasis respondent’s own)

R60 clearly understood the risks he was taking and was aware of the consequences of seroconverting, but still took risks. He engaged with the staff at his sexual health clinic and was tested on a regular basis. Therefore, contrary to the irresponsibility presented by R371 above, those who sought PrEP showed a great deal of reflection about their sex lives.

Conclusions

Disclosure of serostatus proved divisive for respondents, even though the majority felt that men should not be forced to reveal their status on public profiles. Seropositive men did not want to infect others, but were also reluctant to disclose because of the moral judgements by seronegative men in the form of HIV stigma. However, seronegative men felt that disclosure, whether or not on profiles, would allow them to make ‘informed’ choices in relation to sex. For

some, this information would allow them to decide if they wanted to have sex with someone who was seropositive, which contributed to the established HIV stigma in the communities. Therefore, it was unlikely that seropositive men would chose to disclose their serostatus as long as these judgements were being made.

Strong notions of responsibility also arose in relation to disclosure. Among seropositive men there was a reliance on the notion of mutual responsibility; the notion that both partners in an encounter were responsible for their own sexual health. However, seronegative men assumed that it was the responsibility of the seropositive partner to disclose their serostatus to them at an appropriate stage, which varied among respondents. This appropriated blame to the seropositive individual if seroconversion occurred. As seronegative men made assumptions about a partner's serostatus, they benchmarked their own behaviour as responsible, while seropositive men who did not disclose were judged to be irresponsible. This points to a need for seronegative men to be encouraged not to assume that they will be informed of a partner's positive serostatus prior to engaging in sex and/or take a partner's stated serostatus for granted. Greater awareness of the effect of HIV stigma must also be encouraged, so seronegative men understand the reasons why seropositive men are reluctant to disclose their serostatus.

As a result of the moral judgements made by seronegative about their seropositive counterparts, respondents to the survey used a variety of cues to understand serostatus from profiles. However, being aware of the impact of HIV stigma, many understood that such profiles often contained inaccuracies, which caused them to be more critical and questioning of the information presented in profiles. Nevertheless, it was clear that respondents used a variety of cues to try to understand serostatus from profiles in the online world before meeting. There was a reliance on the term 'safer sex only', which was primarily used to identify a profile as seronegative. The absence of the term was also noted by many respondents in *Anytimebloke's*

profile and used to justify their decision to label him as seropositive. Those who were seen to be primarily looking for a relationship were understood to be seronegative, while emphasis on sexual encounters led respondents to believe the owner of the profile was seropositive. Respondents showed an understanding of how sexual role impacted on HIV risk and incorporated this information into their decisions about serostatus. Lesser used cues included judging profiles by the 'look' of the individual and determining how sexual role affected serostatus. These lesser used cues were often based upon stereotypes of individuals, which were generally left unquestioned. Respondents also used a variety of allusions in the 'real' world to indicate their serostatus to other men. Seropositive men were more likely to use such allusions in comparison to their seronegative counterparts. A wide variety of allusions were used, but further analysis showed that the same allusions were being used by seronegative and seropositive respondents to indicate differing serostatuses. This points to a need for MSM to be informed of the difficulties with non-verbal cues in both the real and the online worlds and how these can be misunderstood by different people to indicate differing serostatuses. If men believe that there is only one way to understand these cues, they are likely to continue to use them in the same way as they have done previously. It is only with greater discussion about how misunderstandings can arise with cues that men will understand the risks they pose to themselves when serosorting for partners.

After the negotiating process, respondents felt that they were often left to make decisions about safer sex based upon intuition and guesswork. If they had doubts about their potential partner being an irresponsible *other*, they could opt for condom usage or a risk reduction strategy. While some respondents expressed a commitment to condom use, many did so in a qualified way. Those who chose to employ a risk reduction strategy were more likely to choose serosorting above other methods. This method was particularly common among those who had intentionally sought bareback from someone other than a CRP. Respondents held primarily

negative views about PrEP as a possible risk reduction strategy, mainly due to its potential to increase other STIs and difficulties adhering to the treatment regime. However, they were more optimistic about other men taking PrEP if it becomes widely available in the future. These results point to a need for sexual health promoters to emphasise the problems that arise with serosorting, such as the need for wider regular testing and better knowledge of the window testing period etc. In addition, given the effectiveness of PrEP in the medical trials, more needs to be done to encourage men to think positively about this risk reduction method. Central to this is to ensure that men see themselves at risk of acquiring HIV and not minimise their own risk-taking through the creation of irresponsible *others*.

Chapter Nine - Discussion

Introduction

This chapter takes the findings that have been discussed and relates these back to the existing literature as presented in the review. This will highlight the similarities and differences between my own findings and those reported by other research, which will be discussed further in the conclusion chapter. In addition, this chapter will examine the consequences of the findings for sexual health promoters and workers in order to create an understanding of the consequences of this research and the implications this has for policy and practice the field of sexual health promotion.

Respondents' understanding of HIV risk

Experts in the field of HIV are able to define high-risk sexual activity; most notably that bareback sex between serodiscordant partners puts them at risk of HIV acquisition, but it was evident from my findings that knowledge of risk is acquired through a number of filtering stages (Coulter, 1999), as respondents did not all define risk in the same way as these experts. Almost three-quarters of respondents to the survey - across all age ranges, sexual roles and relationship statuses - had engaged in bareback sex with someone other than a CRP, which was considerably higher than the 56.6% reported to the European MSM Internet Survey (2013). However, my respondents did not necessarily understand these practices as something that placed them at a high risk of HIV acquisition. Indeed, their previous experiences of bareback sex may have taken place in the context of a long-term, monogamous relationship with a seroconcordant partner and/or they may have tested since their last experience and therefore no longer considered this a sexual risk. However, a slight majority of those who had previously been diagnosed with two STIs simultaneously felt that they were at risk of acquiring HIV. However, those who were

engaging in other high risk-taking activities, such as serosorting, barebacking and intentionally barebacking, did not see themselves at significant risk of HIV acquisition. This reflects the differences between observed and perceived risk observed by Kesler et al. (2016). Therefore, the link between high-risk sexual activity and HIV acquisition may be more complex than previously thought. This suggests that a risk continuum may exist in the MSM communities, in which certain high risk-taking activities are perceived to pose less risk than others. Therefore, it is evident that risk understanding may not be the same as experts in the field, suggesting that more needs to be done to highlight the risks MSM face when engaging in activities such as barebacking and other high-risk activities such as serosorting. While increasing knowledge of HIV among MSM has been a cornerstone of much sexual health promotion through the years (Ford, 2011), my findings indicate that increasing knowledge should continue to ensure that MSM understand the risk associated with particular sexual activities. This knowledge will allow them to reduce their risk of HIV acquisition should they require to do so.

Most of the respondents who had engaged in bareback sex had not intentionally sought such sex, suggesting that they may have found themselves in a position where they had engaged in bareback sex without prior forethought. However, the findings indicate that those who had intentionally sought bareback sex from partners were not purposely seeking to become infected with HIV. Only a small number of respondents identified as 'bug-chasers', which may, as Dean (2009) has suggested, confer 'masculine capital' on them. However, further analysis of these respondents revealed that they were either seropositive already, or had utilised risk reduction strategies with partners, which suggests that they actively sought to reduce their risk of HIV acquisition. Therefore, while they may have acquired 'masculine capital' from identifying as a 'bug-chaser', their sexual behaviour did not always reflect this self-identification.

Nevertheless, it was clear that some men, although small in number, made a strong association between masculinities and risk-taking behaviours; most notably in discussions of semen exchange. In a similar manner to respondents studied by Ridge (2004), these men made associations between high-risk sexual activity and masculinities. This link was also evident in respondents' discussions about the images presented in Appendix Three, where respondents identified a particularly masculine image with risky sex. However, those who spoke about semen exchange also explained the centrality of semen to their sexual encounters. A number of these respondents identified semen exchange in the context of intimacy in a way similar to that identified by Schilder et al. (2008). For these respondents, this intimacy, which was central to their experiences of bareback sex, was nullified by condom use. In this context, semen was highly erotised and acted as a fundamental element of sex, leading R184 to describe sex without semen exchange as 'almost pointless', or what R402 refers to as 'unnatural'. Given the desirability of semen exchange to these respondents, which reflects Klein's findings (2016), the promotion of condom usage among men who associate masculinities with risky sex/semen exchange will remain challenging for sexual health promoters (Hickson, 2011).

The majority of seronegative respondents stated that they had never had, or were unsure about having, sex with a man they knew to be seropositive. The primary justifications given by respondents for their rejection of seropositive men were fear of condom failure and/or seroconversion. It is possible that this fear arose from dated associations between HIV and death articulated by a number of younger respondents and those who had never tested/received a HIV result. This suggests that these respondents had very little knowledge or understanding of the progress made by antiretrovirals since the late-1990s and reflects French et al.'s findings (2014) that knowledge of sexual health among key groups of MSM is poor. Given that this group did not have knowledge of the benefits of antiretrovirals, it is unlikely that they

would have knowledge of the subsequent biomedical advances (i.e. PEP, PrEP) made since. However, many respondents who expressed fearful opinions about having sex with seropositive men were also engaging in high-risk sexual behaviours with men who they knew, or presumed, to be seronegative. Therefore, while Elford et al. (2000) and Kelly et al. (1998) suggest that the effectiveness of antiretrovirals may be causing men to reassess their risk of HIV acquisition, it is clear that, for these respondents, this was not the case. The opinions expressed by these respondents indicate no significant association between treatment optimism and the increased sexual risk, which concurs with the research of Kalichman et al. (2007) and Dukers et al. (2001). This points to a continued need for greater knowledge among the seronegative population to challenge dated assumptions about the relationship between HIV and death and ensure they have the most current knowledge available to them about their risk of HIV acquisition from seropositive men.

Relationship structures

The majority of respondents to the survey had not made an agreement with their partner permitting them to have sex with other men. While one may assume that this implies that these couples are monogamous, this was not necessarily be the case. In a similar manner to Shernoff (2006a), how respondents defined 'monogamy' varied considerably between respondents in my research. For example, while the vast majority of respondents felt that any form of oral or anal sex would be a breach of monogamy, a number suggested that their definition of monogamy was more fluid than rigid. This is embodied by what R24 labelled as being his 'monogamish' relationship, where he feels he can be committed to his primary partner, whilst also having sex with other men. This suggests that monogamy may not be defined in the same way by all respondents and indicates the existence of some resistance to traditional definitions of

monogamy. It could be argued that this resistance is a form of transgression against the intensified need to be seen as what Bell & Binnie (2000) defined as a 'good gay citizen' in increasingly homonormative communities. While this may also be evidence of what Lupton & Tulloch (2002) identified as an example of transgression that they found at the heart of the discourse of emotional engagement, it was one of the few examples of transgression found in this research.

In line with this thinking, Blasband & Peplau (1985) discussed how those in 'monogamous' relationships may sleep with other men, while those in open relationships may never act upon their agreement. A small number of my respondents, who had made an agreement with their partner to have sex with other men, did not act out on this agreement, although a number of these had made their agreements 'recently'. In addition, almost a third of those in 'monogamous' relationships had not remained faithful to their partners during periods of monogamy. Relationships like these do not sit comfortably in what are traditionally defined as open or monogamous relationships. As Parsons et al. (2013) have suggested, this dichotomy failed to encompass the diversity of relationship structures in the MSM communities. Therefore, the creation of the term 'monogamish' by R24 also perhaps goes some way to challenging the binary oppositions of open vs. monogamous relationships that are often presented to MSM in research on relationships. If researchers persist to work within these traditional binaries, they will continue to encounter difficulties in trying to understand the exact nature of relationships within the MSM communities.

It was clear that respondents in 'monogamous' relationships who had sex with other men, understood that there would be consequences for their primary relationship, if their partner found out about their deceit. Therefore, these men had reason to remain silent about their

indiscretion, even though they might expose their primary partner to risk of HIV/STI infection. It was for reasons like these that many men in Adam's research (2006) suggested that open relationships were more honest and agreements were more likely to be managed than those within monogamous relationships. In a similar way, many respondents in open relationships justified their behaviour on the basis of their honesty vis-à-vis monogamous relationships. However, my findings indicated that almost thirty percent of men in open relationships also broke an element of their relationship agreement, which was comparable with the result found by Mitchell (2014). A remarkably similar percentage of men in 'monogamous' relationships had sex with another man/men, suggesting that men in both open and monogamous relationships were equally likely to break an element of their relationship agreement. Therefore, the assumption that men in open relationships were more likely to be honest than were their monogamous counterparts was not borne out in this research. Whilst this supports Prestage et al.'s (2008) argument that agreements made in open relationships are likely to be kept, these agreements are no more likely to be kept than those made in monogamous relationships. Therefore, it can be contended that open relationships do not, in effect, provide a better means of reducing the possibility of HIV acquisition to primary partners. While sexual health promoters are aware of the challenges posed by relationship structures in the MSM communities and do not seek to prevent their formation (Hickson, 2011), in line with the recommendation that interventions should account for the individual's values and preferences (Hickson, 2015), it may be that there are opportunities for them to dispel the belief that such relationships are less likely to facilitate HIV transmission.

Relationship agreements made by respondents in open relationships were varied and complex. However, it became clear that many respondents had implicit arrangements, with R19, for example, believing that his partner understood elements of their agreement without discussion,

while others identified having broken their relationship agreement with respect to an element that was not agreed with their partners. In addition, it was evident that some respondents had not made agreements about the use of casual/regular partners and/or condom use. While Duncan et al. (2015b) found that monogamous relationship agreements were often implicit in nature, similar implicitly emerged in my findings with regard to open relationships. Misunderstandings and lack of clarity in relationship agreements may have consequences for the sexual health of primary partners in open relationships, as men may engage in certain activities that their partner presumes to have been excluded in their relationship agreement. Given that many newly formed couples attend sexual health clinics in order to ensure seroconcordance, this may present sexual health workers with a unique opportunity to focus men's attention on relationship agreements at an opportune time. It may be an appropriate time to offer men entering into, or already in established relationships, one-to-one relationship counselling and support to enable to make them aware of the importance of explicit relationship agreements, be they open or otherwise, and the consequences these have for their sexual health.

Among those who did have relationship agreements, the theme of intimacy emerged as something that was normally kept exclusively for the primary partner. These intimate acts, such as sleeping over, indicated that many of my respondents maintained their open relationships by preserving these more intimate acts for their primary partner. It was when this intimacy was shared with other men that relationship agreements were most likely to be broken. These findings undermine Bonello's (2009) assertion that open relationships are often based on compartmentalisation, i.e. the separation of sex from emotions. This research has indicated that these emotions are based around the preservation of intimacy for the primary partner. Undoubtedly, the maintenance of intimacy in the primary relationship will minimise the

likelihood of emotions, such as jealousy, arising that may lead to difficulties within the primary relationship. However, these emotions are likely to be triggered as a result of an intimate act occurring with other men. Therefore, while it is evident that respondents in open relationships were able to disassociate some forms of sex from emotions, the more intimate acts set out in their relationships agreements proved not so easy to separate in practice.

Bonello & Cross (2010) further associate the ability to compartmentalise sex and emotions with masculinities. Given the distinction between sex and intimacy, it could be suggested that respondents in open relationships were able to compartmentalise sex and emotion to an extent and may have gained 'masculine capital' from this separation. However, this compartmentalisation was likely to break down if relationship agreements based upon intimacy were not sustained. This indicates that, while respondents in open relationships may have been able to gain 'masculine capital' by being able to engage in extra-dyadic sex while maintaining their own relationship, this capital was likely to diminish if intimate sex was engaged in. Therefore, any 'masculine capital' that respondents could gain from an open relationship was wholly dependent on the nature of the sex the respondent and/or his partner were having with other men.

The emergence of an ideal relationship type and the rise of the legitimate actor

It was apparent from the findings that the majority of respondents, both single and partnered, held primarily positive views of monogamy, even though half of those in such relationships stated that they had some difficulty remaining monogamous to their partner. These positive views of monogamy reflect sentiments similar to those expressed to Adam (2006) in his research

on monogamy. However, such positive views of monogamy are perhaps unsurprising given the focus placed on monogamous gay relationships since the beginning of the normalisation project in the early years of the new millennium (Neary, 2014). This focus on homonormativities (Duggan 2002) and the subsequent introduction of gay marriage during the course of this research has perhaps embedded an 'ideal' type of relationship based on notions of love, commitment and fidelity. It also perhaps goes some way to explain why my respondents were considerably less likely to describe their relationships as 'open' (31.2%, N: 103) in comparison to the 56.3% who identified their relationship in a similar way to Hickson et al. (1994). This shift towards the aforementioned 'ideal' type of relationship may be presenting MSMs with a new type of relationship structure to which they can aspire and embedding homonormativities in the communities (Duggan, 2002), suggesting some degree of success for the normalisation project.

Butler (2002), when first questioning the consequences of the possible introduction of gay marriage, asked if the expansion of the institution of marriage to gay people would raise moral judgements about those who did not wish to engage in it, thus creating a new hierarchy distinguishing between legitimate and *illegitimate* sexual arrangements. My findings not only confirm that such a hierarchy has arisen, but also that many of my respondents sought to place themselves in the category of the legitimate by focusing on the immorality of an *illegitimate other*, i.e. those who place themselves at deliberate risk of HIV acquisition. This was true, even when respondents' own behaviour was quite similar to those who they deemed to be *illegitimate*. In my findings, the *illegitimate* were imagined *others*, created by respondents in order to sanitise their own risk-taking behaviours. Therefore, it was perhaps no surprise that many alternative discourses of sexual risk-taking were suppressed in this research and replaced by language more representative of Neary's (2014) normalisation project.

This strong moral discourse was notable in that it marked a significant shift away from the celebration of sexual transgression that was previously evident in numerous MSM communities (Lupton & Tulloch, 2002; Ridge, 2004; Beasley, 2010, Hickson, 2011). Many respondents employed a variety of derogatory terms to describe Juan and/or his behaviour and were critical of his decision not to be insistent about condom use. However, while this may have been interpreted as a repetition of the condom code, the strength and forcefulness of these responses and their strong moral dimension was compelling and unanticipated. This was particularly notable as respondents were asked to take the role of Juan's friend and advise him about his decision. This strength of feeling about Juan's decision was most evident when some respondents, such as R236, stated that it was necessary for them to dissolve their friendship with Juan, most likely because of the stigma of being associated with the *illegitimate other*. In addition, respondents who related to Juan's reasoning and decision not to be insistent about condoms were keen to tell him that his decision was not the correct one. For these respondents, it was more important to present themselves as the legitimate actor than it was to express empathy with Juan. While not as vehemently expressed, a similar discourse was revealed in seronegative respondents' concerns about the use of PrEP. It became evident that respondents held strong beliefs about the type of person who could make use of PrEP. It was in these discussions that respondents revealed much about the *illegitimate other*, whom they contrasted with themselves, in order to minimise the importance of their own risk-taking activities (discussed in the following section). These results are similar to those of Girard (2016) who found that men, even those who previously engaged in bareback sex, were critical of those who barebacked in order to protect themselves and the wider MSM communities from stigmatisation.

What was evident from this process was that respondents exhibited a strong desire to appear as legitimate actors, even though they might also have engaged in *illegitimate* behaviour. It was therefore understandable that the legitimate discourse dominated their discussions. However, one of the consequences of the desire to be seen as legitimate is that alternative discourses around sex and sexuality were muted in the research. This was particularly so for the more transgressive discourses associated with masculinities. For example, a small number of men discussed semen exchange in the context of masculinities and transgression, which contrasts with the dominance of such discourses in Ridge's (2004) research. Apart from this small number, my respondents did not speak about the excitement of breaking rules while barebacking. The vast majority sought to justify their barebacking as something that they did infrequently or when they were out of control of their own actions. By justifying their behaviours in such a way, respondents were actively seeking to be seen as maintaining, rather than transgressing rules.

Therefore, there was a clear change of discourse that has emerged in my research, which has muted alternative discourses around sexual risk-taking that have been previously identified by authors (Lupton & Tulloch, 2002; Ridge, 2004, Beasley, 2010, Lupton, 2011). This change allowed a strong moral discourse to emerge and dominate discussions about sexual risk-taking. One of the consequences of this process was that the strong divisions that have emerged in this research between the legitimate and *illegitimate* sexual actors were likely to be solidified. As discussed, those who were deemed to be *illegitimate* had their character stained and respondents sought to distance themselves from such people. Hence, the *illegitimate others* are likely to be isolated within communities where legitimate actors dominate. However, this does not mean that the legitimate did not engage in *illegitimate* behaviour. When the legitimate engaged in *illegitimate* behaviour, they often rationalised their behaviour and discussed issues that interfered with, what they defined as, their more regular rational behaviours. By explaining

their *illegitimate* behaviour in such a way, they minimised the importance of their own sexual risk-taking and hence did not embody the *illegitimate*.

It is therefore likely that some of these men will continue to take risks with sexual partners believing they can maintain their legitimate status. However, if the sexual partners they chose are like themselves, it is possible that they have also engaged in previous *illegitimate* behaviour. As a result, there is a possibility that legitimate actors are exposing themselves to HIV without an understanding that they are putting themselves at risk of acquiring HIV.

Therefore, wider discussion needs to take place within the communities about the emergence of these new homonormativities (Duggan, 2002). It is evident that the introduction of the new ideal type relationship structures in the form of civil partnership and gay marriage has brought many benefits to the communities and have created greater equality between homosexual and heterosexuals in relation to partnership recognition. In itself, this is a cause for celebration. Indeed, it could be argued if such recognition had been available to men during the AIDS crisis, it would have been a tremendous benefit both for those men who were dying and those who survived. However, if this recognition also brings about further divisions in the MSM communities, in which one group - those who avail of, or show intention to avail of, partnership recognition - dominates the other, then discussion needs to take place and steps need to take place to ensure that these divisions do not deepen further and/or have consequences for sexual health. It is possible that social diffusion interventions and wider advocacy may help to challenge the new homonormativities (Duggan, 2002) and the potential consequences for sexual health. As Chauvin & Yeatman (2015, 83) point out, 'advocacy creates the conditions for social change...[and] are not confined to any single location or setting'. Therefore, advocacy could be

used to shift the communities' opinions on this emerging ideal relationship structures and its consequences for sexual health.

The process of 'othering'

Many respondents to my survey who presented themselves as legitimate actors were also engaging in high-risk sexual behaviour that were similar to those they associated with the *illegitimate other*. Therefore, an imagined *other* was created in order to generate distance between their own risk-taking behaviours and that taken by those they deemed to be *illegitimate*. This resonates strongly with Douglas' (1985) and Joffe's (2003) conceptions of risk and the creation of an *other*, in which blame is placed on those who engage in such *illegitimate* behaviours. In this separation of the self from the *other*, the respondents were also able to disassociate the risk associated with the *other* from themselves and hence they maintained their legitimate status. As a result, the legitimate, who are in the majority, believe they can protect themselves against the risk of HIV infection by focussing on the actions of the minority – the *illegitimate other* – and believe themselves not to be at the same risk when engaging in *illegitimate* behaviours.

While Wilkinson (2006) suggests that othering may lead to risk becoming associated with strategies of exclusion and avoidance, this does not mean that the legitimate actors were necessarily avoiding or excluding behaviours associated with the *illegitimate*. Indeed, they would avoid men who they believed to be illegitimate, but not necessarily *illegitimate* behaviour. However, when discussing their own previous risk-taking behaviours, my respondents explained their *illegitimate* behaviours by emphasising the infrequent nature of

such behaviour and/or being out of control because of alcohol/drugs consumption, sexual role etc. This justified the respondents' behaviour in their own mind, so their character was not stained in the same way as the *illegitimate others*. Therefore, it could be suggested that the *illegitimate other* embodied risk-taking while the legitimate actor took similar sexual risks, but were not embodied by their behaviour. Therefore, the legitimate actor can temporarily enter the *illegitimate* role, but emerges with his legitimate status intact. It can be argued that it was this process of *othering* that created, as Butler (2002) had predicted, a hierarchy distinguishing between the legitimate actor (i.e. the respondent) and the imagined, embodied *illegitimate other*.

These *illegitimate others* were most commonly personified in the creation of the more promiscuous/sexually risky *other*. Those in relationships *othered* the promiscuous/sexually risky to legitimise their own relationship as morally superior in comparison with the single, and hence presumed promiscuous, *other*. However, single men also engaged in a similar process of *othering* by comparing themselves with men who were more promiscuous than themselves. This comparison was used by respondents – both those with few and those with many partners – signifying the variation that existed in the definition of promiscuity. Therefore, there was a belief that there was always someone more promiscuous than the respondent with whom they could favourably compare themselves. From this perspective, the respondents underscored their own position as the legitimate actor in comparison with the *illegitimate other*. This may go some way to explain the differences between actual and perceived HIV risk noted by Kesler et al. (2016). While first identified in the initial discourses on HIV/AIDS in the early eighties (Flowers, 2001), these findings show that the focus on the more promiscuous/sexually risky *other* remains present in current discourses about HIV. However, while the earlier discourses about promiscuous *others* were imposed on the MSM communities by the heterosexual

majority in the eighties, this research has found that these discourses are also now being imposed from within. Therefore, the very discourses that MSM fought against in the early days of the AIDS crisis are now being applied to, and even imposed, by those within these communities.

However, the process of *othering* within the MSM communities has been wider than the othering identified by Flowers (2001). Botnick (2000) identified *othering* that resulted from the introduction of HIV-antibody testing, in which the communities could be divided between those who were seropositive and seronegative. Flowers (2001) noted similar divisions that have emerged between those who were detectable and undetectable since the introduction of viral load testing. However, both these *otherings* have stemmed from biomedical advances in the medical profession. The *othering* process that has emerged from this research is qualitatively different from these previous *otherings*, in that it has stemmed from social, rather than biomedical, change. This *othering* process has also gone beyond divisions between seropositive and seronegative communities and creates new divisions along lines of sexual risk. Therefore, it was important for both seronegative and seropositive respondents to *appear* as if they were responsible by avoiding sexual risks and hence maintain their legitimate status.

This need to *appear* as a legitimate actor was evident in the responses from those who stated they would use condoms, even when faced with conflicts when they were aroused. Many of these respondents failed to say how they would enact safety in such situations, apart from physically removing themselves from the situation. The likelihood of this happening is questionable. Nevertheless, they maintained that they would use condoms, even in challenging situations such as the one presented in the 'I really should say something about condoms...' message. However, further analysis revealed that most of these respondents who expressed

such a commitment to condom usage had previously engaged in bareback sex with someone other than their CRP and/or spoke about condom use in a qualified way. Therefore, their desire to *appear* as legitimate actors by making statements about commitment to condom use was not always categorical or reflected in their previous behaviour. In addition, R431 expressed surprise that *Anytimebloke* would 'openly' admit a proclivity for saunas and group sex on his profile. This suggests that, while one may have a preference for such activities, which are likely to be interpreted as *illegitimate*, my respondents were aware that they should not *appear* to condone such behaviour in profiles. This indicates the importance of *appearing* to be a legitimate actor for respondents, even when they were not, in practice, wholly committed to condom usage.

While the current *othering* process identified in my research has expanded to include those who are not seropositive, it is seronegative men who retained control over the *othering* process. Consequently, it was unlikely that seronegative men would apply the *illegitimate* label to themselves, even when they engage in *illegitimate* behaviour. For example, it was clear from my findings that a number of seronegative men were barebacking, yet were not testing for HIV according to the minimum recommended testing cycle. This presented serious health risks for these serosorters, particularly if a partner revealed that he was seronegative, but had already seroconverted. Therefore, while these men may have believed that they were seronegative, there was a possibility that they may have inadvertently passed on the virus to other men. Indeed, the latest statistics from Skingsley et al. (2015a) identified a large number MSM being diagnosed with HIV at a later stage of infection, which indicates that these men were not testing on an annual, or more frequent, basis. However, none of my respondents who tested infrequently and were engaging in barebacking identified themselves as being *illegitimate*. Therefore, as long as they remained in control of the *othering* process, seronegative men maintain control over how their behaviour was defined.

This process of *othering* creates difficulties for making men understand their risk of acquiring HIV. If men continue to identify *illegitimate others* as those who embody risk, they are unlikely to perceive sex with legitimate actors as risky. While sexual health promoters understand the social norms that evolve around sex (Hickson, 2011), they may not be aware of the process of othering identified in this research and the impact it may have on the sexual health of MSM.

Managing *Illegitimate* behaviours in the negotiation process

Even though respondents may not always have engaged in legitimate sexual practices, they still had reason not to present themselves as and avoid the *illegitimate other*. Those who wished to dissolve their friendship with Juan because of his behaviour also showed an awareness of a stigma attached to being labelled as an *illegitimate other*. This process of *othering* reflects earlier processes identified by Joffe (2003), the resulting strategies of exclusion discussed by Wilkinson (2006) and the process of 'stigmatisation-by-association' (Walker, 2007). In my research, the divisions created by the *othering* process were between the legitimate actor and the *illegitimate other*, both of which may contain seropositive men. Therefore, it was necessary for legitimate actor to present themselves as legitimate, even when they had engaged in *illegitimate* behaviour. Many respondents did this by placing emphasis on a loss of control and the infrequency of their *illegitimate* behaviour. A number of my respondents justified their behaviour by explaining the intensity of the sexual situation and the effect that this had on their ability to negotiate safer sex. While these respondents showed an understanding of the risks they were taking, they felt that desire interfered with their ability to negotiate condom usage. This is similar to Holmes and Williams' (2005) research which found that a sense of dissonance occurs when safer sex comes into conflict with desire. Passion and desire to have sex were seen to influence their rational, decision-making capacities, of which condom use was a central part.

Another aspect of the sexual situation that respondents used to justify previous *illegitimate* behaviour related to references to their sexual role. This was particularly an issue for men when they were in the receptive position. In a similar way to McInnes et al. (2011), respondents who took the receptive role did not feel able to assert their desire for safer sex for fear of undermining their partner's implicit dominant role in sex. This shifting of responsibility for safer sex to the active partner meant that their ability to negotiate safer sex while in the receptive role was diminished. However, while passing over control to the active partner, these respondents were also placing themselves at a far greater risk of HIV acquisition while in the receptive position. Therefore, even though the receptive partner might slip into the *illegitimate* by putting themselves at significantly increased risk of HIV acquisition, they justified their behaviour by reference to their sexual role and hence were able to retain their legitimate status.

It was also evident from the findings that a substantial proportion of respondents consumed alcohol and/or had previously engaged in drug usage. In addition, a significant number of these respondents had used drugs in combination with one another, or with alcohol. Although crystal meth and its dangers are currently receiving much attention in the MSM media, it was the drug least-commonly consumed by respondents in this survey. Nevertheless, many of these respondents explained that they felt out of control of their actions while high on drugs and/or alcohol. As Hess et al. (2014) have pointed out, MSM who engage in binge drinking are also more likely to engage in injecting drug use and sexually risky behaviour. While many respondents to my survey identified themselves as 'moderate' drinkers, they often described situations where they had lost control of their ability to think rationally when under the influence of alcohol. This suggests that binge drinking and drug use were issues for respondents, which affected their ability to use condoms and/or engage in risk reduction strategies. However, these respondents also compared this behaviour when high to when they were not under the

influence of alcohol or drugs. In doing so, they emphasised the infrequent nature of their behaviour and hence retained their legitimate status.

These findings point to times when men have difficulties using condoms and therefore could provide useful information to sexual health promoters. Sexual health promoters are aware of these difficulties and aim to increase men's understanding of the potential consequences of their actions and present them with the ability to pursue their own choices. This may include making them aware of time when they feel they have little control over the sexual situation and providing them with negotiation skills to increase their confidence in their abilities to assert a desire for safer sex. Small structured group interventions may work best in this regard, as they have previously proven to be effective in these types of behavioural changes (Harding et al., 2004 cited in Hickson, 2011). However, one of the key criticisms of group interventions is that they may attract those who already have an interest in the topic, rather than attracting those with the greatest need of the intervention (Nutland & Weatherburn, 2015). Therefore, careful consideration should be given to advertising and attracting those who are most likely to benefit from this intervention.

The role of disclosure in the negotiation process

The *othering* process used by my respondents moved the process beyond the seropositive communities and has widened to include *illegitimate* seronegative *others*. While Johnston (1995) found moral divisions between the seropositive and seronegative communities in his research, my findings suggested that this had expanded to include those seronegative men who take risks with their sexual health. This was not to say that serostatus was unimportant for

respondents. The majority of both seronegative and seropositive respondents felt that seropositive men should not be forced to reveal their serostatus on public profiles. However, many seronegative men expressed a desire to know this information and some would use this information to reject seropositive partners, similar to sentiments expressed by seronegative respondents studied by Murphy et al. (2015a). The rejection of seropositive partners was the primary form of HIV stigma reported by seropositive men in Stirratt's (2005) research and is one that was repeated in this research. Nevertheless, while many seropositive men expressed a desire to inform partners of their serostatus, as was evident in Ridge et al. (2007), and seronegative men sought this information, the likelihood of rejection resulting from disclosure means that was unlikely to occur. This mirrored Smit et al.'s (2012) finding that HIV was heavily stigmatised within the communities, inhibiting disclosure.

While many seronegative men sought to be informed about their partner's serostatus, they were unlikely to request this information from partners. Instead, in a similar manner to findings from Murphy et al. (2015a), they felt seropositive men had more responsibility lay to inform them. Hence, it was the legitimate seropositive actor who revealed his serostatus to seronegative partners, while the *illegitimate* seropositive *other* chose not to disclose. However, seronegative men were unclear about what was an appropriate stage for the legitimate seropositive actor to disclose. While some respondents, such as R242, identified a precise point for disclosure that both partners could measure (before meeting in 'real' life), others were less exact in their decisions (before sex/relationship). Therefore, the message from seronegative men to their seropositive counterparts about disclosure was one of confusion and hence, difficult for seropositive men to measure.

On the other hand, most seropositive respondents were committed to the notion of mutual responsibility. From this perspective, both parties had an equal responsibility to protect themselves and it was not the sole responsibility of the seropositive partner to disclose. This is in marked difference to Wolitski et al.'s research (2003), which found that two-thirds of seropositive men felt that it was their responsibility to inform partners of their serostatus. Mutual responsibility was also in direct conflict with the notion of individual responsibility that was asserted by seronegative respondents in this research. If both parties are adhering to the responsibility structure that they deemed most appropriate, then there was potential for misunderstandings between partners.

Perhaps due to the advances in viral load monitoring and the consequences for onward transmission of HIV, some seropositive respondents felt that disclosure was not always necessary, or only necessary at the point of risky sex. This is in line with Keogh's (2008) findings that seropositive men may not disclose their serostatus given the reduced risk they pose to other men, particularly when engaging in certain types of sex. However, a problem that was raised by this research is that seronegative and seropositive men define risky sex differently, which further confounds the challenges of disclosure.

These findings have sexual health implications for both seropositive and seronegative men. The potential for misunderstandings between the two groups is great given the different standpoints of both sets of men. Seronegative men need to be more aware of the reduced risk from having sex with seropositive men who have an undetectable viral load. They also need to be aware of the consequences of rejection on the disclosure process and on the already established HIV stigma within the communities (Earnshaw & Chaudoir, 2009; Nyblade & MacQuarrie, 2006). They also need to be aware that while they have high expectation of disclosure, they should not

expect that all seropositive men will disclose their serostatus to them. Therefore, while encouraging seronegative and seropositive men to disclose their serostatus to enable each group to have knowledge of perception of their own risk, sexual health promoters could provide techniques for seronegative men to ask and accept a positive disclosure. On the other hand, seropositive men also need to be more aware that seronegative men expect a seropositive partner to disclose their serostatus. Therefore, it should not be taken for granted that a partner will take an equal role in protecting themselves from HIV acquisition. It may be that an internet-based intervention would be effective to inform and challenge perceptions about disclosure and the risk from seropositive men, as they have previously proved effective in improving sexual health knowledge (Hickson, 2011). However, while internet-based interventions have proven successful at reaching marginalised populations, questions have been raised about accessing people with literacy difficulties, those who are offline and about trust issues when information is presented online (Nutland, 2015).

The non-verbal nature of the negotiation process

Given that seronegative respondents waited for seropositive men to disclose their serostatus and that seropositive respondents expected seronegative men to take responsibility for their own health, it is perhaps no surprise that many respondents negotiated safer sex in a non-verbal manner. Delph (1978, cited in Roberts 2006) found that non-verbal negotiation was particularly common in more anonymous sexual cultures. R508, who described himself as a 'cruisy' gay man, emphasised the code of silence that he encountered when he anonymously engaged in sex with other men. In such locations, he did not feel he had the ability to negotiate safer sex, since to break the code of silence was contrary to the specific nature of the sexual encounter. This suggests that the code of silence that Delph (1978) identified over thirty-five years ago is still

embedded in the modern anonymous sexual cultures. This longstanding interpretation of the code of silence in such locations is therefore very difficult for sexual health promoters to dispel.

Adam et al. (2008) also found that non-verbal communication was often equated by some men with assent for bareback sex. As discussed, some seronegative respondents assumed they would be informed if their partner was seropositive. In a similar manner to the findings of Flowers et al. (2000), these respondents might not have felt the need to discuss safer sex with partners, as their default position was to assume that their partner was seronegative, unless informed otherwise. However, R367 spoke about insisting on condom use when in the receptive position, but not in the active role, unless specifically requested by his partner. In this case, R367 took the silence of the receptive partner as permission to engage in unsafe sex. This confirmed Adam et al.'s findings (2008) and indicated how silence was still taken as permission for some men to engage in bareback sex with other men.

However, respondents were also keenly aware the effect on the sexual situation of introducing a discussion about condoms. As Holland et al. (1998) pointed out, speaking about condoms meant not only talking about sex, but also inferring that your partner presented a sexual risk and hence, belonged to the *illegitimate Rother*. It was noted by R539 that such a discussion about condoms implied that his partner was a potential risk, which had the potential to destroy the desire in the encounter. As a result, he was aware that speaking to a partner about condoms at an inopportune moment was likely to have negative impact on the sexual encounter. If one wanted to maintain sexual desire in such an encounter, then there was reason not to engage in such discussions, as R539 implied.

Therefore, if men continue to associate discussions about condom usage with suggesting that their partner belongs to the *illegitimate* other, non-negotiation of condom use may be reinforced in the communities. It was evident that techniques for introducing condoms into the sexual situation in a way that could contribute to, rather than impact upon, the sexual situation need to be produced, so that men have a way to remain in the sexual situation without impacting on desire. This is particularly important for receptive partners who may not feel they have ability to assert a desire for safer sex. Encouraging men to understand condom use as a means of showing care and respect for a partner, rather than suggesting that implies something negative about the partner may be a way to do this. In addition, active partners need to be more aware that a receptive partner may desire safer sex and silence should not be automatically taken as assent for bareback sex. However, this will remain challenging if the introduction of condoms remains associated with the *illegitimate others*.

Filtering out the *illegitimate other* in the online world

Given the challenges and the stigma that may result from disclosure, it was not surprising that many respondents chose other non-verbal means of communicating about serostatus. This was in line with Persson et al.'s (2016) research, which found that half of their respondents did not communicate serostatus at last sex with casual partners. Nevertheless, serostatus remained crucially important for many respondents in the filtering process. The growth of internet/app dating in the MSM communities identified in the literature by Mowlabocus (2010) and Avery (2013) meant that this form of communication was likely to be the first point of contact for many men seeking sexual partners. Therefore, it was also a necessary starting point for filtering out the *illegitimate others*. However, in a similar manner to findings from Grov et al. (2013), respondents were mindful that untruths were presented on such profiles, suggesting a need for

men to filter out *illegitimate others* by interpreting the content of profiles. Many such sites/apps do not allow for a person to specify their serostatus in drop-down menus and, because of the established HIV stigma in the communities, it is likely that men will continue to be dissuaded from disclosing their serostatus in open text boxes.

However, it was evident from my findings that the majority of respondents relied heavily upon the term 'safer sex only' as a means of filtering out the *illegitimate other*. Those who used the term were assumed to be seronegative, while those who omitted it were deemed to be seropositive. The fact that respondents noticed the omission on *Anytimebloke's* profile indicated the importance of this term when filtering. Some respondents, such as R492 and R455, questioned the meaning of the term 'safer sex only', but went on to identify men who used this term on profiles as seronegative. However, Adam (2005) found that there were different understandings of the term 'safer sex only' between seropositive and seronegative men. While the vast majority of my respondents associated the term with seronegativity, it was also used by a number of seropositive men to allude to their serostatus. While Horvath et al. (2008) suggested that seropositive men may deliberately misrepresent their serostatus on profiles, 'safer sex only' was also used by seropositive men to indicate the necessity of condom use with potential partners. Nevertheless, the consequence of this misunderstanding is that confusion about serostatus may arise between men, particularly if such profiles are used as a means of serosorting.

Another method used by my respondents to filter the *illegitimate other* was to examine a preference for sex over a relationship in profiles. It was in these conversations that a clear moral tone re-emerged. When examining the two mock profiles, respondents made links between those who expressed a desire for a relationship and the legitimate actor. Many

respondents identified *Anytimebloke* as likely to be seropositive on the basis of his preference for group sex and saunas. While *Anytimebloke* also expressed a desire for a relationship, he was identified by my respondents as belonging to the *illegitimate other* on the basis of his stated partiality for sexual activity that was not believed could lead to a potential relationship. This was in contrast to *Hungasahorse*, who also sought a relationship. However, *Hungasahorse's* sexual preferences were more ordinary than *Anytimebloke's* and hence he was more likely to be identified as a legitimate actor. Goldenberg et al. (2015) found that emotions such as love, intimacy and trust influenced men's decisions about sexual risk and it is possible that respondents' emphasis on relationships may be indicative of emotion affecting risk understanding.

There were also several other lesser-used cues that respondents garnered from profiles in order to assess serostatus. Those who identified sexual role usually had some knowledge of the effect sexual role could have on HIV acquisition/transmission. Many other cues were also used, but decisions made on these were often based on limited knowledge, such as in the case of bisexuality, usernames or decisions based on gut feelings or appearances. Most importantly, however, cues garnered from profiles were rarely used in isolation and a number could be used simultaneously to come to a conclusion about the *legitimacy* of an individual. Therefore, reasoning in this filtering process was a complex one. Several respondents, such as R421, reflected on their decisions about serostatus whilst writing their responses. However, it is probable that decisions made in the 'real' world are likely to be made more swiftly from those made in the 'research' world and these reflections may not necessarily be part of filtering in their everyday experiences.

Although the filtering of profiles was complex, there remained a number of ways for sexual health promoters to challenge the conclusions that men make about partners from perusing

such profiles. The key way in which men identified an *other* was through the use of the term 'safer sex only'. The vast majority of respondents implied that this suggested that the man in such a profile was seronegative and therefore more likely to be legitimate. However, while this term was predominantly used by seronegative men, seropositive men also used it to indicate a desire to protect others. In a similar way, a profile that was more sexual in nature was deemed to be representative of someone who was seropositive. However, it was evident that these assumptions need to be challenged in order to ensure that men have a better understanding of this non-verbal way of negotiating sex. Given that much of this negotiation happens online, an internet-based intervention may be a useful way of targeting men who make use of this form of negotiation at an appropriate time.

Filtering in the 'real' world

While some filtering used by my respondents took place online, an ongoing process of filtering was also likely to continue in the 'real' world. The main methods used by respondents to filter in the 'real' world was to use allusions to serostatus. Just over a quarter of respondents said they had used such allusions. However, while respondents may have believed they were having discussions about serostatus, this may or may not have been the case. For example, they may have felt that such a discussion was not necessary given the type of sex they were engaging in, or may have believed their partner was seroconcordant on the basis of filtering carried out online. As with the findings of Stirratt (2005), this research found that seropositive men were far more likely to allude to their serostatus than their seronegative counterparts. The principal justification for the use of allusions was because of HIV stigma in the communities. The most commonly used allusions were to state on profiles that they had safer sex only, dropping hints about their serostatus, and by telling their partner that there was no need for condoms. The

primary environmental cue used by respondents was to leave condoms around in tacit preparation for sex. A smaller number of respondents made use of normative cues to indicate their serostatus to potential partners. Hoff and Kamchikanti (2002) found that seropositive men commonly used normative cues to indicate their serostatus and that not all men have the same understandings of these cues. However, this research found that both seropositive and seronegative men used normative cues. However, further analysis confirmed that both seropositive and seronegative men were using the same allusions to indicate differing serostatuses. This points to the difficulty with such cues, as Hoff and Kamchikanti (2002) indicated. If these respondents engaged in bareback sex with someone they assumed to be of the same serostatus because of an allusion given, then they may have unwittingly exposed themselves to the virus. However, R344 stated that he used a variety of allusions, not only to indicate his own serostatus to his partner, but also to understand his partner's serostatus. Therefore, it is likely that allusions are not being used in isolation and not solely to indicate serostatus, but also as a means to interrogate other men about their own serostatus.

In much the same way as filtering in the online world, allusions to serostatus have the potential to be misunderstood. Therefore, it is imperative that such allusions be challenged and men should be encouraged not to rely on them as a means of interpreting serostatus. Therefore, awareness of the difficulties with allusions need to be raised, so that confusion does not rise between partners. This points to the importance of serostatus disclosure and that expectations of disclosure may not be always been made. It is possible that small structured group interventions may be effective here to encourage behavioural change (Hickson, 2011).

The results of the filtering process

At the end of the filtering process, men have to make a decision about whether or not to use condoms with another man. Even with the extensiveness of the filtering process, some of my respondents felt that they made decisions about serostatus and the need for condoms based upon guesswork or intuition. This indicates that they were conscious of the fact that filtering was not a seamless process and that, at times, it was not a successful means of understanding if a potential partner is a legitimate actor. However if respondents were unsure about the risk associated with a potential partner, yet sought to engage in bareback sex, they had the option to select from a number of risk reduction strategies to minimise their HIV risk.

The least-commonly employed risk reduction strategies were viral-sorting and withdrawal. Viral-sorting required that a man be open to the possibility of having sex with a partner who they know to be seropositive and depended on a detailed understanding of the effect of viral loads on the possibility of HIV transmission. However as discussed, many seronegative men stated they would not have sex with a seropositive man and did not show awareness of the developments made by antiretrovirals. Therefore, these men were unlikely to be aware that they could utilise viral-sorting as a risk reduction strategy. Nevertheless, viral-sorting was more commonly used by those who had intentionally sought bareback sex, indicating that some of these respondents had the knowledge required to employ this risk reduction strategy. Although withdrawal was an option for most respondents, it was equally unpopular. In their decision not to make use of withdrawal as a risk reduction strategy, it was possible that respondents were aware of the limited success of withdrawal as a means to reduce the risk of pregnancy in the heterosexual communities. Applying this knowledge about the potential of premature

ejaculatory fluid, it was conceivable that they applied similar reasoning about the effectiveness of withdrawal as a method for minimising HIV transmission.

Strategic positioning was a risk reduction strategy that involved a partner consciously choosing to take the active role in bareback sex as a means of minimising HIV transmission (Suarez & Miller, 2001) and was used by a third of my respondents. Interestingly, in comparison to viral-sorting, this method was equally common across those who had, and those who had not, intentionally sought bareback sex. However, the most commonly used risk reduction strategy was serosorting. Rowniak (2009) described serosorting as the practice of choosing to have unprotected sex with a partner of the same *known* serostatus. While preferred by a significant minority of those who sought bareback sex from someone other than a CRP, it was far more frequently used by those who had intentionally sought bareback sex. This suggests that those who were intentionally seeking bareback sex might have a greater understanding of the risks they were taking and were taking steps to minimise that risk. Nevertheless, key to effective serosorting was knowledge of both partners' definitive serostatuses. However, analysis of my results has shown that almost one third of those who had engaged in serosorting were not fully aware of their serostatus because they had never tested for HIV, not received a HIV result, or were not tested within the minimum recommended testing cycle. Therefore, it was likely that these respondents were engaging in seroguessing (Zablotska et al., 2009). While believing they were using serosorting as a means to reduce their HIV risk, these men were placing themselves at increased risk of HIV acquisition. On the other hand, one fifth of those who engaged in serosorting were testing at least once every three months, which indicated that they were aware of the recommended testing cycle for those who are placing themselves at risk of HIV transmission. While these men might be seen to be taking responsibility for their sexual health,

the window period for HIV tests means that their results cannot be taken as a guarantee of serostatus.

As already discussed, a strong moral discourse was present in much of the discussion about the potential use of PrEP as a risk reduction strategy. At the time of data collection, conflicting reports about the effectiveness of PrEP were dominant in research emanating from the various trials. At the time of the research, the trials had indicated an efficacy rate of between 44% (Liegler et al., 2014) and 73% (Mujugira et al., 2011). Since then, it has become clearer that PrEP is highly effective at reducing HIV acquisition in men with high-risk sex lives, as evidenced by McCormack et al. (2016) and Molina et al. (2015). However, my respondents held primarily negative opinions about PrEP, with many expressing concern that it will make seronegative men more reliant on HIV medications and the potential rise in other STIs. Given the overall effectiveness of PrEP (even at the time of data collection), only half of respondents felt that PrEP would decrease the number of new HIV infections. This points to a need for sexual health promoters to highlight the effectiveness of PrEP emerging from the most recent research, so that those who are most in need can access it if/when it becomes available on the NHS.

However, PrEP is also dependent on men identifying their sexual behaviour as something that places them at risk of HIV acquisition. However, my findings also indicated that many respondents who were actively taking risks in their sex lives were not identifying themselves as at risk of HIV acquisition. This will present a major challenge for those trying to promote PrEP use within the communities. While men who acknowledge their risk (the *illegitimate others*) may access PrEP to minimise their HIV risk, those who take infrequent risks (the legitimate actors) may be unlikely to identify their need for PrEP and continue to place themselves at increased risk of HIV acquisition.

It is evident that many men who utilised a risk reduction strategy were engaging in serosorting. However, there are many difficulties with serosorting, particular if men are not fully aware of the serostatus. Given that a third of serosorters were not fully aware of their serostatus yet engaging in bareback sex with other men, the potential for HIV transmission between these partners is high. Therefore, it is clear that sexual health promoters need to continue to target men who are using risk-reduction strategies to minimise the potential of HIV transmission. This may require increasing knowledge of the risks associated with these strategies, particularly when men are not testing accordingly and promoting the benefits of condom use for MSM. Greater awareness of the continued success of the PrEP trials also needs to be promoted, so that more men are aware of the potential of the drug. This promotion could be targeted at high-risk MSM, through the use of one-to-one or small group interventions. The positive promotion of PrEP is particularly important to ensure that the 'PrEP whore' shaming discourse about PrEP that has been so prevalent in the United States (Spieldenner, 2016) does not hinder men from coming forth for the drug in the UK. Continuing media advocacy and community education may help raise awareness of PrEP and its potential benefits in protecting men from acquiring HIV and challenge the assumptions that give rise to a 'PreP whore' shaming discourse (Hickson, 2011).

Conclusions

This discussion brought together the main themes that emerged from the findings sections and discussed them in relation to the literature examined in the review. Of central importance to this was how respondents to my survey understood HIV risk. Respondents understood risk in a number of different ways from experts, suggesting that sexual health knowledge may be poor, as French et al. (2014) found in their research. A continuum of risk emerged in which some risks were considered greater than others. How respondents understood their relationship

structures was also explored, indicating that traditional notions of monogamy and open relationships were too rigid in a similar way to Shernoff (2006a). This dichotomy limited respondents' experiences of their relationship structures, as was evidenced in Parson et al.'s (2013) research. In addition, similar to findings of Adam (2006), respondents in open relationships asserted that they were more honest than those in monogamous ones were. However, respondents in open relationships were equally likely to break an element of their relationship agreement, indicating that they were no better placed to protect the primary partner from STI/HIV infection, as Baggaley et al. (2010) suggested. However, it was clear that a new 'ideal type' relationship was evolving as a result of the normalisation project (Neary, 2014), which has given rise to legitimised sexual arrangements driven by a strong moral discourse (Duncan et al., 2015a). The *illegitimates* were isolated within the communities in which legitimate actors dominate. While those who were legitimate engaged in *illegitimate* sexual activity at times, they placed emphasis on the infrequent nature of such activity, or of being out of control, and therefore did not embody the *illegitimate* in the same way the *illegitimate other* did.

In order to minimise the importance of their own risk-taking, the legitimate had an interest in the creation of an imagined *illegitimate other* in a similar way to other othering processes (Joffe, 2003; Wilkinson, 2006). The primary way for the legitimate actor to create an *illegitimate other* was to focus on promiscuous/sexually risky behaviour. In contrast with previous identified otherings (Flowers, 2001; Botnick, 2000; Johnston, 1995), this othering process had materialised as a result of social, rather than biomedical change. While seropositive men could be included in the legitimate (by being 'responsible' for disclosure), it was seronegative men who maintained control of labelling the *illegitimate other*. Respondents also revealed an awareness of the stigma of being labelled *illegitimate* and therefore sought to protect themselves from being labelled by

emphasising the infrequent nature of their *illegitimate* behaviour and/or lacking control over the situation. In this way, they sought to present their own behaviour as legitimate, even while engaging in *illegitimate* behaviour.

While disclosure would have allowed both partners to make decisions about the type of sexual activity they wished to engage in, the established HIV stigma discussed by respondents meant that such disclosure was unlikely to happen (Smit et al., 2012 cited in Murphy et al., 2015b). Seropositive respondents embraced the notion of mutual responsibility and were less likely to disclose their serostatus that reported in Wolitiski et al. (2003), while their seronegative counterparts adopted individual responsibility. If both parties felt the other partner was embracing the other's conventions, misunderstandings were likely to occur. Seronegative men also had different understandings of when it was appropriate for a seropositive man to disclose meaning that it was unclear when a seropositive man should reveal his status to a partner. This was likely to give rise to non-verbal forms of communication about serostatus. While non-verbal communication remained as dominant in anonymous sexual cultures as it did over thirty years ago (Delph, 1978), other respondents indicated that they interpreted silence about condom use as assent for bareback sex, as was similar to the findings of Adam et al. (2008). A number of respondents also identified the consequences that talking about safer sex can have on the sexual situation, possibly due to the implication that their partner belongs to the *illegitimate other*.

Serostatus proved important for respondents in the filtering process, particularly when reading online profiles. In a similar way as they did in research by Adam (2005), many of my respondents relied on the term 'safer sex only' to identify a man as seronegative. The importance of this term to respondents was revealed when many noticed its omission on *Anytimebloke's* profile who was labelled seropositive as a result. Other means of identifying serostatus included an

emphasis on sex over relationships, with those emphasising sex labelled as seropositive. However, it was clear that many respondents used a combination of cues from profiles to make decisions about serostatus, underlining the complexity of this process. While respondents made use of the online method as a means of filtering the *illegitimate other*, other men continued to read cues in the 'real' world, similar to those identified by Hoff & Kamichikanti (2002). The findings revealed that both seropositive and seronegative men used the same cues to indicate serostatus to potential partners. As was the findings of Adam et al. (2008), this was likely to give rise to confusion between partners who may have different understandings of the same cue. However, cues can be used as a two way process in which men can both indicate and seek information about their partner's serostatus.

At the end of the filtering process, men had to make a decision about condom usage or utilising a number of risk reduction strategies, if they thought there was a possibility that their partner was a part of the *illegitimate other*. Both strategic positioning (Suarez & Miller, 2001) and serosorting (Rowniak, 2009) were the most common risk reduction strategies used by respondents. However, further analysis indicated that those who believed they were serosorting may have been seroguessing (Zablotska et al., 2009). This was because they either had not tested for HIV or did not test at the appropriate frequency to have knowledge of their serostatus. Even if they were testing on a regular basis, respondents may be misunderstanding the window period in HIV testing, meaning that they may be putting themselves and/or their partners at increased risk of HIV transmission. This pointed to the difficulty of serosorting as a means of protecting men when engaging in bareback sex with others.

Chapter Ten - Conclusion

Methodological implications

In line with Bryman's (2012) recommendations, the online survey was innovative and there was some uncertainty whether or not this particular method would secure the type of data required to complete this research. It was evident from the response rate, which was significantly higher than other internet surveys (Sill & Song, 2002), that many respondents engaged with the survey, even though it involved a considerable time commitment. One of my main concerns about the time commitment was the difficulty in estimating how long it would take respondents to complete the survey. The estimation given to respondents at the beginning of the survey was that completion would take between twenty and thirty minutes. However, the complexity of the branching within the survey, the number of open questions and the likely variation in typing speeds meant that presenting an exact timeframe for completing the survey was challenging. In order to give respondents a visible representation of their progress through the survey, a progress bar was included. It is evident that the inclusion of the progress bar, together with the structure of the survey and the use of images to maintain respondent's interest meant that respondents were able to engage with and complete the survey within an acceptable timeframe.

The use of visuals in the survey proved popular with respondents and allowed nuanced understandings of the specific mass media interventions to inform me of their risk perception and response. It was likely that they also maintained respondents' interest to complete this survey by providing stimulus material and respite from pages of questioning, as Bryman (2012) had recommended. The mass media interventions also allowed respondents to reflect on aspects of their own sex lives by contextualising certain situations in which they may have found themselves. This was particularly the case for the 'I really should say something about condoms' intervention, when respondents spoke about the challenges of maintaining rational thinking

about condom use during moments of intense sexual arousal. Their responses revealed much about their knowledge, or lack thereof, of how to deal with a conflict similar to the one presented in the message. Therefore, while questions related to these messages themselves, they also served as a means to prompt discussion about the respondent's own lives and difficulties.

In addition to the mass media interventions, other images were used in the survey. Much time was spent on construction of the two mock profiles used in the survey. It was important that these profiles were similar to profiles that men found on websites and/or phone applications, such as Gaydar and Grindr. The images used were carefully chosen and the text supplied replicated the content from a variety of sites/apps. The success of these mock profiles was reflected in the fact that no respondents commented on their construction, suggesting that they were an accurate reflection of the profiles they encountered in their everyday lives. In addition, the findings obtained from these profiles have indicated how respondents understood serostatus from profiles and the varied processes they used to arrive at these conclusions. It was clear from the responses to the profiles that the respondents did not become disengaged from the survey and were keen to express their reasoning for labelling the profile as seronegative or seropositive. Without the successful construction of the mock profiles, it would be challenging for me to obtain the extent of information that emerged from this part of the survey.

How respondents would respond to a detailed mixed methods online survey about sexual health was of particular concern prior to the launch of the survey. It was unclear if this mixed method approach would be effective at gaining the depth and complexity of information required for the successful outcome of this research, as it did for Mayoh et al. (2012). This was particularly

true for the qualitative data in the survey. While much research pointed to the success of the individual methods and smaller scale mixed methods studies in the online context (Mayoh et al., 2012), it was uncertain if this research would produce nuanced qualitative data that could be meaningfully interpreted alongside the quantitative data. However, the findings from this survey revealed that such nuanced qualitative data can be secured through the online method to create detailed results that allowed for comprehensive and nuanced stories to emerge. This was most apparent in the differences that appeared between what respondents said they would do in certain circumstances (as emerged from the qualitative data) and what they actually reported doing (in the quantitative data). These disparities have contributed to the construction of the *illegitimate other* and highlighted the consequences for sexual health promoters. While such stories may have also emerged in the course of qualitative research, the advantage for this research is that the number of respondents to this research indicate the extent of such stories among far greater numbers of men than could be covered by individual qualitative researchers in such a short timeframe.

The ability to collect data from a large number of respondents across the UK was one of the main advantages of the online approach (Wright, 2005). Almost half of the respondents to this survey hailed from cities and towns outside the twelve major urban areas listed in the survey. This suggested that this survey captured a vast range of men from different locations throughout the UK. Replicating such research through traditional methods and capturing the opinions of MSM from such a variety of locations would not have been possible for a single researcher within the five months the survey was live. It was also likely that this survey captured some men who were unlikely to have engaged with other forms of qualitative research. The anonymity provided by an online survey indicated that respondents could reply to sensitive and intimate questioning without the fear of being identified. In addition, groups of men who may have been reluctant

to engage with sexual health researchers were encouraged to complete this research (Raymond et al., 2010). For example, several men who identified as barebackers completed the survey after a link was retweeted by the co-founder of the Bareback Brotherhood in the UK. Given that these men were likely to have opinions that ran contrary to the condom code and those espoused by sexual health promoters, it is conceivable to suggest that such people were more likely to engage in this research format than with face-to-face researchers (Toerien & Wilkinson, 2004).

The OUHEC raised several pertinent issues in relation to this study. One of the concerns raised related to the ‘challenging’ language in the survey, an issue encountered by Huby and Hamer (1994) in their research. However, this issue was not raised by any respondents after survey completion suggesting that an appropriate balance between formal and colloquial language was found. While it was plausible that some of those who did not complete the survey may have found the language challenging, the high completion rate in comparison with similar research suggests that the number of such respondents was marginal. The committee also recommended that the majority of demographic questions should be removed in order to maximise anonymity and ensure the university face no ethical difficulties in relation to the intentional/reckless transmission of HIV. While entirely possible within a sexual health survey with open text responses, no respondents admitted to intentional/reckless transmission, although a number demonstrated an awareness of the laws. The robust defence mounted in favour of the collection of demographics has been justified on the basis that they subsequently became central to the story that emerged in the findings. For example, age became a central issue for respondents when identifying the *illegitimate other*. Without the ability to record respondents’ ages, it would have become impossible to construct such an argument. Therefore, the collection of demographic data has been essential for the successful outcome of this

research. One of the compromises that was made was in relation to the inclusion of demographics was the addition of 'rather not say', 'none of the above' and 'other' options to close several demographic questions. However, even with these options, the vast majority of respondents were willing to provide demographics. The largest number of respondents who chose such an option was fourteen for the question related to highest educational qualification. The loss of this information, which was negligible in comparison to the amount of information gained from the collection of wider demographics, allowed respondents who were uncomfortable with providing information to progress through the survey when they otherwise might have dropped out. Therefore, the inclusion of these additional options was beneficial to the overall research.

While helplines to various organisations were provided at the end of the survey, the BSA ethical guidelines (2002) also recommends that researchers attempt to minimise or alleviate potential distress caused by research. Given the sensitive nature of questioning in the survey, I was particularly aware of the potential impact this research could have on respondents (Lee, 1993). One of the final questions offered respondents the opportunity to contribute additional information about themselves that was not covered in other parts of the survey. While this was an optional question, several respondents included information about themselves that further contextualised their stories. Some respondents identified themselves as sexual health promoters and highlighted their extensive knowledge of the research topic. Others developed their responses after reflecting on the survey as a whole. However, some respondents took the opportunity to express highly sensitive information about their pasts, including their experiences of bareback sex through rape⁴¹. Given that respondents were willing to offer such personal information in their responses to this question, it was evident that it was important for

⁴¹ No identification of any individual was made in these responses.

them to be able to contextualise and reflect upon their responses in a way that I could not have predicted during the period of survey construction. Therefore, this question had the dual purpose of allowing respondents to express their reflections on the survey as a whole, while also allowing them to ensure that *their own stories* were expressed, and not solely the stories that I, as the researcher, sought. While there has been criticism about the representativeness of such responses at the end of quantitative postal surveys (Gracia et al., 2004), this question proved invaluable to this research and allowed respondents to contextualise their responses in ways that could not be predicted. In comparison to purely quantitative approach in Gracia et al's (2004) research, the mixed method approach in this research implied that respondents would be more accustomed to the qualitative approach by the end of the survey. In addition, the question in this survey was constructed to be optional and therefore a response from each respondent was not part of its overall objective. However, the information gathered from the question, along with its capacity to alleviate potential distress by allowing respondents to express their reflections proved that its inclusion was more beneficial than detrimental to this research.

While there were many advantages of utilising this method for this research, it was also important to acknowledge the limitations and the role of the researcher in the research process. A great deal of time was invested in the construction of the survey prior to data collection to ensure that questions were clear, precise and avoided any double meanings, as recommended by Bryman (2012). The number of branches in the survey were particularly difficult to manage and it was necessary to test each individual branch prior to the launch of the survey to ensure that respondents only faced questions that were related to their own particular situation. The complexity of these branches made it challenging to arrange the survey in a manner that was logical for every respondent. In addition, many questions had to be moved throughout the

survey construction stage and consideration had to be given to the impact of these moves on each individual branch of the survey. Therefore, while branching has many advantages for respondents to an online survey (Wright, 2005), they can also create various challenges for the researcher during the survey construction stage.

One of the main difficulties with this method became particularly evident during the analysis stage of the qualitative data. At times, respondents spoke about certain issues in their responses, which were not sufficiently developed or were unclear. For example, while some respondents spoke of risk, it was unclear what specific risk they spoke about. This was particularly so for men who discussed risk in the context of their open relationship. In such circumstances, it was occasionally unclear if the risk respondents discussed was the risk to their sexual health, or their relationship. In an interview setting, researchers are able to probe these confusions to ensure that there is proper understanding of individual responses (Silverman, 2013). However, the online survey method does not present researchers with the opportunity to probe and therefore some meanings remained frustratingly unclear.

Theoretical implications

From the results, it was evident that the theories of health promotion discussed in the literature were not, or were only partially, applicable to this research. This was most notable with the Health Beliefs Model (Nettleton, 2006), which asserted that people will take steps to avoid risk if they understood they are vulnerable to a threat. In a similar way, the AIDS Risk Reduction Model (Catania et al., 1990) failed to address the core aspects of my findings, as while respondents were putting themselves at risk of HIV acquisition, they did not necessarily

understand these risks in the same way. The Stages of Change Model listed a number of stages through which one must progressed to successfully change a behaviour. While some respondents could be located in certain stages of the model, the nature of questioning in this survey meant that it was difficult to place respondents in all stages of the model. The Situated Rationality Approach (Bloor, 1995b) suggested that people made rational decisions based upon their definition of the situation they were in. While this approach has some applicability to men in open relationships who use condoms in extra-dyadic encounters, the fact that they might be using condoms as a means of protecting intimacy in the primary relationship casts doubt on the theory's effectiveness for this research. Bloor's work on the Systems of Relevances (1995a) and the differences between habitual and calculative action had only limited application to these findings. The COM-B model (Michie et al., 2011) emphasised the relationship that capability, opportunity and motivation has on behaviour. Many of the responses that respondents gave to questions could be located within capability, opportunity and motivation and therefore this theory goes some way to explain how behaviour can be located within the wider Behaviour Change Wheel. However, Douglas & Chavez's (1990) cultures of risk approach also explains the more social aspects of these findings. Instead of a four-box grid present by Douglas & Chavez, I suggest that a circle is more appropriate in which the legitimate dominate over the *illegitimate*, but into which the legitimate may enter temporarily depending on their behaviour. It will become evident that the circle gives the flexibility required to explain much of behaviours of respondents to the survey.

The Health Beliefs Model (HBM) asserted that when a person understood they were vulnerable to a threat and the consequences of that threat, they would take action balancing benefits and costs (Nettleton, 2006). The theory posited that men, once they understood they were at risk of HIV acquisition, would balance the benefit of sexual pleasure (barebacking) with the costs

(HIV acquisition). Even though respondents understood risk in different ways, none of the respondents implied that they were not, or that their actions never put them, at risk of HIV acquisition. Therefore, they had an understanding that their sexual practices may have placed them at risk of HIV acquisition. The HBM suggested that these men would therefore take steps to avoid the possibility of HIV acquisition by not placing themselves at risk of the threat. However, a significant proportion of respondents had engaged in bareback sex with someone other than a CRP, which suggested that many were taking risks with their sexual health in the knowledge that their behaviour placed them at risk of HIV acquisition. Therefore, the HBM was not a theory that helped me understand why MSM took risks with knowledge of the potential consequences.

The HBM was developed by Rosenstock et al. (1988) to incorporate cognitive theory and self-efficacy, which lead to the creation of the AIDS Risk Reduction Model (ARRM) (Catania et al., 1990). Central to this theory was that when men recognised and labelled their behaviour as high-risk, they committed to reducing this behaviour and sought to enact strategies to control their behaviours. However, as revealed within the risk continuum, many respondents were taking risks with their sexual health without fully understanding, or ignoring the possible consequences of their risk-taking. Therefore, while they were aware that they were vulnerable to HIV, they did not consider the risks they were taking as sufficient to place them at a heightened risk of acquiring the virus. If men did not understand their behaviour as high-risk, then they were unlikely to commit to reducing such behaviour and/or enact strategies to reduce it. While the ARRM may have had greater applicability at the time it was written (prior to the introduction of antiretrovirals), it has limited applicability to this research as only a limited number of respondents interpreted their behaviours as placing them at risk of HIV acquisition.

The Stages of Changes model (SoCM) (Prochaska & DiClemente, 1984) listed a number of stages through which one progressed to successfully change a behaviour. Therefore, behavioural change was an on-going process depending on the motivation of the individual to change. However, in order for change to be made, knowledge was required about the need to change. As many of my respondents who engaged in high-risk behaviours did not see themselves as being at risk of HIV acquisition, we could say that these respondents were in the precontemplation stage. It was only when they became aware of the potential risks that they could progress beyond this stage. From my findings, it was unclear where many of my other respondents were on the SoCM. However, one respondent, R87, stated that he was unclear how to deal with the conflict that appeared in the 'I really should say something about condoms...' intervention. This respondent indicated that he had knowledge of the challenges involved with rational thinking at moments of sexual intensity, but did not know how to progress with change. This suggested that this respondent was in the preparation stage of the SoCM. However, one development of the SoCM that was very relevant to my findings was the influence of internal and external environments on behavioural change (DiClemente, 2005). It was clear that many respondents noted the influence of alcohol and/or drugs on their intended behaviours. Therefore, if these men were in environments that allowed or accommodated such behaviours, then this was significantly likely to influence how that individual progressed through the model. For example, R493 discussed how he made decisions about his sexual health that he would not usually do when he was sober. This implied his more regular behaviour changed when he was under the influence of alcohol. Therefore, his progression through the SoCM was likely to be influenced by his consumption of alcohol. While the SoCM had relevance to some aspects of this work, particularly the developments made by DiClemente (2005), the lack of information gathered about the particular stages means that it was only partially applicable. Further research in this field may indicate greater applicability of the SocM than was obtained in this research.

The Situated Rationality Approach (SRA) (Bloor, 1995b) suggested that people made rational decisions based upon their definition of the situations they were in. Men in open relationships who used condoms during extra-dyadic encounters, but barebacked with their primary partners, have often been taken as evidence of the SRA. However as discussed, men's choices about using condoms in extra-dyadic encounters may very well have been driven by a desire to maintain intimacy in the primary relationship rather than a form of negotiated safety (Halperin, 2007; Rowniak, 2009). Therefore, the rational decision to protect the primary partner from HIV/STI acquisition might also have been interpreted as a rational decision about protecting the intimacy in the primary relationship. This is not to suggest that HIV acquisition was not important to couples when making decisions about condom usage in extra-dyadic encounters, but rather that issues about protecting intimacy within the primary relationship may be just as, or if not more, important than protecting the primary partner from HIV acquisition.

In relation to the SRA, Keogh (2001) stated that the focus on the rational thinker ignored distinctions between the *irrational pre-sex self* and the *rational after-sex self*. Respondents to this survey spoke about a variety of issues that affected their abilities to make rational choices about safer sex prior to engaging in sex. The most notable of these was the effects alcohol and/or drug use had on their abilities to make rational choices. Many of these men compared the choices that they made while under the influence with those made when sober. Therefore, they were aware that their ability to make rational choices was impaired by the consumption of alcohol and/or drugs. Even when sober, other issues clearly effected some men's judgements about condom use. This was particularly an issue for men in the receptive position during sex, as they felt their ability to suggest condom use was affected by the implicit receptive role during sex. Therefore, even if these men had made a rational decision about condom use, their ability to assert that desire was compromised by their role in sex. For others again, their heightened

state of arousal affected their abilities to make rational choices. Therefore, it was clear that the assumption underpinning the SRA about men's ability to make rational choices to protect themselves depending on the situation they were in was complicated by the findings in this research. While respondents to this survey desired to protect themselves from HIV acquisition and hence were reluctant to describe themselves as 'bug-chasers', this process was often complicated by a variety of issues relating to alcohol/drug consumption, their state of arousal and/or their role in sex.

Bloor's (1995a) phenomenological analysis of Schutz's 'systems of revelances' (1970) highlighted the importance of habitual action in risk assessments. The 'systems of revelances' combined elements of both habitual and calculative actions to understand men's risk assessments. While this theory overcomes the structural nature of other theories, it did not appear to any great extent in this research. There were several respondents who spoke about making risk assessments in their own mind, before relying on intuition or guesswork to make a final decision. This implied a combination of calculative and possible habitual action. However, this was the limited evidence of Bloor's analysis in this research. While the results indicate that Bloor's application of Schutz's 'systems of revelances' (1970) was not evident in this research, it is possible that a more in-depth qualitative research might have revealed more of Bloor's analysis.

The COM-B model, which is at the heart of the Behaviour Change Wheel (BCW) (Michie et al., 2011) emphasised the relationship that capability, opportunity and motivation has on behaviour. Both opportunity and capability were likely to affect motivation and all three individually had an impact on behaviour. Therefore, if an individual did not have the opportunity or capability to carry out a particular behaviour, then this was likely to impact on their motivation to do so. However, almost half of my respondents stated that they had not used a

condom because they were unable to access one when needed. In addition, as R436 pointed out, he did not carry condoms in tacit preparation for sex because of the potential opportunity for embarrassment this may cause if the condom was seen at an inappropriate time. Therefore, he only carried condoms when he had the intention to have sex, limiting his opportunity to use condoms when sex happens unintentionally. This lack of access to condoms pointed not only to missed opportunities for these respondents, but it also affected their capability to have safer sex, which was subsequently likely to have impacted upon their motivation to change behaviour. However, other issues, such as a lack of control over the sexual situation and use of alcohol and/or drugs were likely to affect men's capability to assert a desire for condom usage. This lack of control men had over the sexual situation was also likely to impact on the motivation to use condoms. The difference between reflective and automatic motivation was captured in many of the responses about this lack of control. These responses indicated that automatic motivation dominated when respondents felt out of control of the sexual situation. In situations like these, men presented themselves as out of control of their own destinies, where desire took over from their own instincts to have safer sex. Therefore, their reflective motivation was overcome by automatic motivation in these moments. Therefore, the COM-B Model displayed much relevance to these results. The wider enclosure of the COM-B model within the BCW signified that a series of interventions and policy changes could be used to address respondents behaviours.

However, while the COM-B model can be used to explain respondent's behaviours, the Cultures of Risk approach (CoR) (Douglas & Chavez, 1990) could be used to explain the wider social aspects of his research. The CoR suggested that risk behaviour and response was a product of different socialisation in various subcultures and social institutions. While Douglas & Chavez created a four grid box to identify the various influences on an individual, the findings from this

research indicated that a four box grid was no longer be required. As discussed, the dominance of the gay marriage debate and the rise of homonormativities (Duggan, 2002) has meant that many alternative discourses about sexual risk were muted in my research. The moral discourse that has evolved as a result of the normalisation project (Neary, 2014) was evident in the vast majority of the findings in this research. While a small number of men spoke in transgressive terms, these were negligible in comparison those who engaged in a moral discourse that differentiated the legitimate actor from the *illegitimate other*.

Therefore, I am suggesting that it is possible that Douglas & Chavez's four box grid may be now minimised to a circle in which both the legitimate and the *illegitimate other* revolve. The legitimate dominates the circle, but the *illegitimate other* always has a presence. A circle was chosen instead of a box grid, as an actor can move between the legitimate and the illegitimate depending on their behaviours. However, it was only those who embodied the *illegitimate other* that were a constant in the illegitimate part of the circle. Those who were legitimate may have engaged in illegitimate behaviours, but theirs was only a temporary visit to the illegitimate. Once their engagement with the illegitimate behaviour was over, they reverted back to the legitimate. It was therefore possible to move through the illegitimate, but not occupy that space, unless one comes to embody the illegitimate. If the legitimate actor was deemed to be illegitimate, they remained in the illegitimate, either temporarily or permanently, depending on the opinion of the legitimate majority. As mentioned previously, the legitimate, who were predominantly seronegative men, controlled the definition of illegitimacy and therefore the decision whether or not someone remained within the *illegitimate* or returned to legitimacy was theirs. This process is represented in the figure below.

Figure 11.1: The Circle of Legitimacy



While different subcultures may have influenced MSM previously in accordance with each subculture's rules and norms, my findings suggested that these have been incorporated into one dominant legitimate discourse that has emerged in line with the new homonormativities (Duggan, 2002).

Reflections on the findings

In this section of the conclusion chapter, I reflect on the findings discussed in chapters five to eight and relate them to the aims of the thesis. In this way, it will become clear to the reader how each of the aims of the thesis has been met. I also include reflections on opportunities for further research in the light of these findings.

To explore how MSM understand their risk of infection in a post-antiretroviral society.

In an era of biomedical prevention technologies, experts are able to define sexual activity that puts MSM at increased risk of HIV acquisition. However, it became clear in my research that there was a 'risk continuum', in which some high-risk sexual activities were perceived by respondents to pose less of a risk than others. For example, while sexual health mass media interventions may present serosorting by seronegative men as a high-risk activity for HIV acquisition, the majority of the seronegative respondents in my research did not have the same understanding. Therefore, it was evident in my research that not all of my respondents had the same understanding of HIV risk as those evident in contemporary mass media interventions. This indicates that knowledge of risk was being acquired by my respondents through a number of filtering stages, similar to that identified by Coulter (1999). As a result, the message from experts that certain high-risk sexual activities placed MSM at increased risk of HIV acquisition was being filtered by my respondents. However, my research did not manage to explore how respondents filter this risk message from experts and therefore further research to understand the mechanisms involved in this process.

Gerrard et al. (1996) and Hess et al. (2015) found that HIV risk understanding and abilities to engage in rational decision-making was strongly influenced by drug and/or alcohol consumption. The vast majority of respondents in my research reported using drugs at some stage in their sexual careers and a significant number has used them in combination with other drugs and/or alcohol. In addition, a significant minority of respondents were aware that drugs and/or alcohol consumption impacted on their decision-making capabilities and a number discussed engaging in sexual activity they would not have done if they had been sober. Therefore, it was evident that there was a possibility that my respondents' risk understanding were influenced by the consumption of alcohol and/or drugs.

The links made by Elford et al. (2000) and Kelly et al. (1998) between the effectiveness of antiretrovirals and the reassessment of HIV risk/increased practice of barebacking were not evident in my findings. In contrast, the majority of seronegative respondents in my research never had, nor would consider having, sex with someone they knew to be seropositive. This suggests that these respondents had little understanding of the effectiveness of antiretrovirals as a means to reduce the possibility of HIV transmission. Many spoke of the fear of condom failure and/or the perceived impact this would have on sex with a seropositive partner, while a number also expressed dated associations between HIV and death. Therefore, it was evident that these respondents perceived that a considerable risk of HIV acquisition came from those who had already been diagnosed with HIV. This indicated a lack of knowledge about the developments of antiretrovirals and the significantly reduced possibility of HIV transmission from seropositive men with undetectable viral loads. In addition, viral-sorting, which requires detailed knowledge of antiretrovirals and viral load levels, was the least-commonly used risk reduction strategy utilised by respondents. Therefore, the link between the effectiveness of antiretrovirals and a reassessment of HIV risk/increased barebacking was not present in my research. This indicates that my research concurs with that of Kalichman et al. (2007) and Dukers et al. (2001) that shows no significant association between treatment optimism and the increased sexual risk.

A significant minority of respondents in my survey had an awareness of the PrEP trials that were being undertaken at the time of data collection. These trials were indicating mixed results (Liegler et al., 2014; Mujugira et al., 2011) and were before the more positive outcomes that emerged from the later PROUD and IPERGAY trials (McCromack et al. 2016; Molina et al. 2015). Respondents held primarily negative views about PrEP, but were more optimistic about the possibility of men using PrEP if it became more widely available. This indicated a degree of

acceptance of PrEP among respondents and suggests that HIV risk understanding may change when PrEP becomes more widely available. However, my respondents also spoke about PrEP in strong moral terms, suggesting that the drug was more appropriate for men who were more promiscuous (than themselves) and/or those took sexual risks (i.e. the *illegitimate other*), even when they had previously engaged in a variety of high-risk behaviours. These findings suggest that the 'PrEP whore' shaming discourse that has evolved in the United States (Spieldenner, 2016), which inhibits many high-risk men from taking PrEP, may be developing in the UK. However, PrEP is an evolving field and the successful results of the more recent research and the newly announced extended trial by the NHS (Cairns & Pebody, 2016) is likely to impact on how MSM understand PrEP's impact on HIV risk understanding. Therefore, there is an ideal opportunity for further research to be carried out on the topic in the future to examine how/if HIV risk understandings change in the light of these progressions.

The discussions of PrEP in my research were part of a larger *othering* discourse that contrasted with previous *othering* processes identified by Flowers (2001), Botnick (2000) and Johnston (1995). While these previous *othering* processes primarily stemmed from a variety of biomedical advances, in my research, factors such as sexual activity, age and scene participation were used as mechanisms to differentiate the respondent's own high-risk sexual behaviours from those who were *illegitimate others*. Even when respondents engaged in high-risk sex, they justified their *illegitimate* behaviour by emphasising the infrequency of such behaviour and/or stating that they were out of control, which concurs with the findings of a variety of authors (Holmes and Williams, 2005; McInnes et al., 2011; Hess et al., 2014). By emphasising the infrequency of their own behaviours, respondents did not embody the *illegitimate other* and maintained their legitimate status. As such, the *othering* process was used by respondents to minimise and sanitise the importance of their own risk-taking and was similar to processes

identified by Douglas (1985) and Joffe (2003). Therefore, the source of the risk became one that is associated with those outside the primary group (the legitimate actors) and onto others (the *illegitimate others*). As Wilkinson (2006) suggested, risk then becomes associated with strategies of avoidance and exclusion. In doing so, the legitimate actors underscored their own risk positioning vis-à-vis the *illegitimate other*. Therefore, it was evident that my respondents understood HIV risk as something that effects *illegitimate others* and that such risk can be circumvented by the avoidance of *illegitimate others*. My respondents believed that this avoidance of the *illegitimate others* protected themselves and other legitimate actors from HIV risk, even when they had previously engaged in high-risk behaviours with those they believe to be legitimate actors.

Summary & Discussion

It was clear that many of my respondents had a different understanding of HIV risk than experts. For example, the majority of my seronegative respondents who had previously engaged in (what they understood to be) serosorting did not consider themselves at risk of acquiring HIV. This points to a need for greater risk awareness in the MSM communities. If the majority of seronegative respondents did not understand their risk of acquiring HIV through serosorting, then they were also less likely to have a HIV test on a regular basis given that they may not define their behaviour as risky. Therefore, more knowledge of HIV risk may not only reduce the possibility of HIV acquisition among serosorters, but may also impact on the onward transmission of HIV to other men. Therefore, it is key to address these discrepancies by emphasising the risk associated with the particular activities within the risk continuum to create better awareness in the communities about HIV risk understanding.

It was evident that my respondents had used a variety of drugs and/or alcohol over their sexual careers and understood that this use had impacted upon their ability to engage in rational thinking prior to sex. Although respondents were reluctant to identify as heavy consumers of alcohol, many reported instances of binge-drinking, where they had made decisions they would not have if they had been sober. While this illustrated the influence of drugs and alcohol had on men's decisions about sex, it also points to a need for the communities to address the wider challenges associated with drug and alcohol consumption. Therefore, it is necessary for sexual health promoters to continue to consider the influence of alcohol and/or drug use on men's abilities to make rational decisions, providing them with meaningful negotiating skills that may assist them in such situations.

The introduction of antiretroviral treatment has had an enormous impact on the life expectancy of seropositive men and use of antiretrovirals, in the form of PEP, PrEP and TasP, has meant that men now have a range of ways in which to minimise their HIV risk. While Elford et al. (2000) and Kelly et al. (1998) suggested that MSM may be reassessing their risk of HIV infection in the light of these developments, this was not evident in my research. Many respondents in my research stated that they would not have sex with someone they knew to be seropositive and expressed the fear of condom failure and/or the effect it may have on the sexual situation. Therefore, it was clear that these respondents, some of whom understood HIV as a terminal diagnosis, believed that the greatest risk of HIV acquisition derived from having sex with seropositive men. However, unlike the aforementioned research, respondents in this research showed very little understanding of the development of antiretrovirals and the effect this can have on onward transmission of the virus. Therefore, similar to research by Kalichman et al. (2007) and Dukers et al. (2001), there was no significant link between treatment optimism and increased sexual risk in my research. This lack of knowledge about the impact of TasP indicated

that respondents were also unlikely to have understandings of PEP or PrEP, which could further minimise their risk of seroconverting if they were exposed to the virus. While there was some resistance to PrEP in my survey, respondents were optimistic that more men would take the drug when it becomes more widely available. Therefore, it is necessary to ensure the effectiveness of antiretrovirals and the successful results of the PrEP/TasP trials is covered widely in the MSM and mainstream medias to increase awareness and challenge dated assumptions about HIV. If MSM receive and understand such information, it may lead to a reassessment of HIV risk in the light of this evidence.

The process of *othering* identified in this research means that respondents in my research, who sought to sanitise their own high-risk behaviours in comparison with imagined *illegitimate others*, were unlikely to fully understand the extent of their own risk-taking. It was also evident that respondents who understood themselves to be legitimate actors actively took steps to ensure that they are not labelled as the *illegitimate other*. Therefore, the appearance of being seen as a legitimate actor was deemed important to these men. Consequently, it was likely that other such 'legitimate actors' were also engaging in *illegitimate* behaviours without appearing as *illegitimate others*. If these 'legitimate actors' engaged in bareback sex with other men who they also believed were legitimate, then there was an increased possibility of HIV transmission in such encounters. Therefore, greater awareness needs to be raised about the *othering* process and the potential impact this may have on HIV risk understandings. Men need to consider their risk of HIV acquisition based on their actions alone, not in comparisons with imagined *others*. Creating this awareness may allow men to make decisions about HIV risk with more complete awareness of the risks they are taking.

To examine how masculinities inform HIV risk and response.

Although the significance of masculinities has been widely discussed in other literature (Shernoff, 2006b, Halkitis, 2000, Grov et al., 2010), masculinities did not play a significant role in the discussions of HIV risk in my research. However, those respondents who utilised a masculine discourse were most likely to make do so in their discussions of semen exchange and when examining one of the images in appendix three of the thesis. For these respondents, semen was highly eroticised and condom use nullified what they understood to be a fundamental element of sex. These results concur with Schilder et al.'s (2008) research on semen exchange and the associations made between high-risk sexual activity and masculinity in Ridge (2004). However, given that only a small minority of my respondents utilised such a discourse, it was clear that alternative discourses of risk, such as the celebration of sexual transgression identified by Dean (2009) and Ridge (2004), were muted in this research. This suggests that masculinity was relatively unimportant to respondents in my research.

Dean (2009) suggested that barebacking, and specifically 'bug-chasing', confers 'masculine capital' on a barebacker. However, in contrast to this research, my respondents who were engaging in bareback sex with other men were not seeking to become infected with the HIV virus and were reluctant to identify as 'bug-chasers'. This suggests that this 'masculine capital' was not an important issue for respondents in this research. Further analysis of the small number of my respondents who identified as 'bug-chasers' revealed that they were either seropositive already, or had employed a variety of risk reduction strategies in order to reduce their HIV risk, suggesting that 'bug-chasing' may have been a fantasy for these respondents. This concurs with the findings of Grov and Parsons (2006) who, while not dismissing the existence of 'bug-chasers', question their existence outside an online domain. Therefore, while these

respondents may have gained 'masculine capital' from identifying as 'bug-chasers', each had engaged in an action to undermine this identification.

Bonello & Cross (2010) further associated compartmentalisation in open relationships with masculinities. Some of my respondents in open relationships may have obtained such 'masculine capital' from engaging in extra-dyadic sex with other men whilst maintaining their primary relationship. However, given the importance placed upon sexual intimacy by many of my respondents in open relationships, it was likely that their ability to compartmentalise, and the 'masculine capital' that emerged from this, would have diminished if their partner had engaged in intimate sex with another man. Therefore, any such 'masculine capital' gained from compartmentalisation was often dependent on the maintenance of sexual intimacy in the primary relationship and was likely to diminish if explicit or implicit agreements about such intimacy were broken. Therefore, in contrast with the findings of Bonello & Cross (2010), my research found that compartmentalisation, and any 'masculine capital' that emerged from it, was dependent on the maintenance of sexual intimacy in the primary relationship.

It was evident from my research that masculinities did not play a significant role in the lives of MSM and that counter-'normative' discourses (Robertson and Williams, 2010), such as the discourse of emotional engagement (Lupton & Tulloch, 2002) and transgression (Ridge, 2004), were not present in much of this research. In contrast with the aforementioned research, some of my respondents actively sought to dissolve a friendship with a virtual transgressor (Juan) in order to dissociate themselves from the stigma of such a friendship, suggesting the use of a strategy of exclusion/avoidance of *illegitimate others* (Wilkinson, 2006). It could be suggested that this new moral hierarchy between the legitimate actor and the *illegitimate other*, which has emerged as a result of the normalisation project (Neary, 2014), played a significant role in the

suppressing alternative transgressive discourses concerning sex and sexual risk-taking. Therefore, it was possible that masculinities may still played a role in the lives of respondents, but that the new moral hierarchy influenced respondents' discussions of alternative discourses in this research. This is a possible avenue for further research in this field.

Summary & Discussion

In much of the literature about masculinities and HIV risk, the focus is on alternative views of risk in which risk is interpreted as more exciting and a means by which men can transgress rules imposed upon them by wider society. The small number of respondents who did speak about masculinities and transgression, most notably in the context of semen exchange, desired semen, which may have placed them at increased risk of HIV acquisition. Nevertheless, overall themes of masculinities were present in only a minority of responses and played no significant role in the responses from those in open relationships in this research. However, given the positive views of monogamy that have emerged since the beginning of the normalisation project in the early years of the new millennium (Neary, 2014), it is perhaps unsurprising that alternative discourses of risk were understated in this research. It is possible that this focus on homonormativities has embedded the 'ideal' type of relationship based on notions of love, commitment and fidelity. This normalisation discourse allows little room for expressions of difference from an 'ideal' form that inhibits transgression. Therefore, it can be suggested that the lack of emphasis placed on masculinities, alternative discourses of risk and transgression by respondents in this research may be understood as a reflection of the growing predominance of the normalisation discourses in the MSM communities. As a result, sexual health workers may need to be aware of the influence of the normalisation project may have on men's discussions about their sexual health. Men who engage in transgressive behaviours may be increasingly

unlikely to be open about their behaviours in such discussions, which may influence the support sexual health workers can give to these men.

To understand how informal/formal relationship agreements impact upon HIV risk.

In line with research carried out by Shernoff (2006a), the traditional, restrictive understandings of 'monogamous' and open relationships were challenged by my findings. Some of my respondents in open relationships had not (yet) engaged in any sex with other men, while a number of respondents in 'monogamous' relationships had sex with other men during periods of monogamy. These results concur with similar research carried out over thirty years ago, suggesting that this trend is well-established in MSM communities (Blasband & Peplau, 1985). While the majority of my respondents held positive views of monogamy, which concurs with research carried out by Adam (2006), some felt that monogamy could be more fluid under particular circumstances. This was particularly evident when a partner lived abroad and/or if sex happened in anonymous locations. In addition, some of my respondents in relationships, both open and 'monogamous', felt they could be monogamous to their partners, yet also engage in sex with other men. Therefore, it was evident that they were able to compartmentalise sex and emotions, something Bonello (2009) states that open relationships are based upon. In contrast, my research has shown evidence of compartmentalisation in both open relationships and 'monogamous' relationships where one partner has had sex with another man/men. This suggests that, for these respondents, monogamy was something more than purely sexual monogamy.

However, the assumption that all sex and emotions can be compartmentalised was challenged by my findings. In their discussions about their open relationships, it became evident that many of my respondents were basing their explicit or implicit relationship agreements on the

maintenance of sexual intimacy within the primary couple. Therefore, relationship agreements were broken when sexual intimacy was shared with others. It is evident, therefore, that while men in open relationships may have been able to separate some forms of sex from emotions, more intimate sex proved more difficult to separate. Therefore, the assumption that all sex and emotion can be compartmentalised (Bonello, 2009) was not one that was reported by many of my respondents. My research suggests that the process of compartmentalisation is more complex than previously thought and may need to be reconsidered to reflect the complexity of relationship agreements and the role that sexual intimacy plays in these agreements.

Many of my respondents in open relationships compared the honesty they understood as inherent in open relationships with the deceit in 'monogamous' relationships where one, or both, partners had sex with other men. This mirrors the results of Adam (2006) who found that open relationships were generally more honest and more likely to be managed, thereby reducing HIV risk within the primary couple. Prestage et al. (2008) also asserted that agreements made in open relationship relationships are more likely to be kept than those in 'monogamous' relationships. However, my results revealed that respondents in open relationships were equally as (un)likely to break an element of their relationship agreement as those in monogamous ones. This was further complicated by my findings that indicated that some open relationship agreements were more implicit than explicit. If misunderstandings about the limitations of relationship agreements are made, it is possible that the HIV risk within the primary couple may increase. Therefore, my research has indicated a need to challenge assumptions about open relationships and HIV risk to ensure that those in such relationships do not assume they have reduced HIV risk in comparison to those in monogamous relationships.

In contrast to research carried out by Hickson et al. (1994), fewer respondents in my research identified their relationship as open. However, it is possible that the number of men opening their relationships has declined as a result of the normalisation project (Neary, 2014), which placed emphasis on the importance of monogamous gay relationship and partner recognition. The strong moral discourse that has emerged between those legitimate actors – those who sought, or had received, partner recognition - and others in the communities suggests that a new hierarchy between legitimate and *illegitimate* sexual arrangements is evolving, as predicted by Butler (2002). It is therefore possible that the number of MSM identifying their relationship as open may continue to decrease with an intensified emphasis on the normalisation project within the communities.

Summary & Discussion

It was evident that non-monogamies created an additional dynamic in MSM's understanding of HIV risk. As with previous research, definitions of 'monogamy' were more fluid than the more traditional dichotomous definition (Shernoff, 2006a). Many respondents in both 'monogamous' and open relationships had sex with other men while stating they were monogamous to their primary partner. While this suggests that these respondents were able to separate sex from emotions, it was evident that sexual intimacy played an important role in the sex men in open relationships had with their primary partners. Therefore, the suggestion that all sex and emotion can be separated was complicated by the importance of sexual intimacy in primary relationships. The vast majority of all respondents expressed positive views of monogamy, whether or not they practised it. However, it is likely that the emphasis placed on monogamous gay coupledness as part of the 'normalisation' project (Neary, 2014) affected the responses. While the 'normalisation' project may create an alternative relationship structure for MSM to

aspire to, it may also increase pressure on them to conceal aspects of their relationships that do not conform to this ideal, increasing HIV risk.

The nature of relationship structures within the MSM communities has often given rise to concern about HIV transmission to primary partners. While it was asserted by respondents in open relationships that their relationships were more likely to be honest than those in deceitful monogamous relationships (Adam, 2006), this was not borne out in this research. Those in open relationships were as likely as their 'monogamous' counterparts to break an element of their relationship agreement and were therefore at the same HIV risk. While negotiated safety can reduce HIV risk, this research found that relationship agreements are more implicit than explicit suggesting that those in such relationships may be placing themselves at increased HIV risk due to possible misunderstandings in the limits of such agreements. This suggests that open relationships do not provide any better means of minimising HIV transmission within the primary relationship.

My findings suggest that the assumption about honesty within open relationships needs to be challenged to ensure that men in such relationships do not assume they have increased protection against acquiring/transmitting HIV within the primary relationship. In addition, given that some of my respondents' relationship agreements were more implicit than explicit suggests that there is the possibility of misunderstandings occurring around the boundaries of such agreements. As such my research would suggest that it is necessary to provide men with techniques for formulating explicit relationship agreements to ensure that both men have a clear understanding of the limitations in such agreements.

To investigate how MSM negotiate sex prior to, and at the point, of sexual engagement.

Honest and open disclosure of serostatus was one way for respondents to negotiate sex, safer or otherwise, with their partners. It was clear that, while expressing a desire to inform their partners of their serostatus, many seropositive men were reluctant to disclose because of HIV stigma, which is similar to the results found by Ridge et al. (2007). However, due to the reduced risk posed to their seronegative partners, seropositive men also believed that each person in a sexual encounter has a responsibility to protect himself and therefore it should not always be incumbent for a seropositive partner to disclose. This shows a marked shift from Wolitski et al.'s research (2003), which found that the majority of seropositive men felt it was their responsibility to disclose. However, given the development of antiretrovirals since these authors' research, it is likely, similar to Keogh's (2008) findings, that seropositive men may not disclose because of the reduced risk they pose to other men particularly if they are undetectable and/or engage in certain types of (safer) sex.

In contrast to the notion of mutual responsibility espoused by seropositive respondents, seronegative respondents assumed that a seropositive partner would inform them of their serostatus and hence did not feel the need to discuss serostatus with others, which concurs with the findings of Flowers et al. (2000). While many seronegative respondents in my research stated that disclosure would enable them to make informed decisions about HIV risk, some admitted they would use such information to exclude seropositive partners, which echoes the findings of Murphy et al. (2015a). Therefore, while disclosure of a positive serostatus could be used as a powerful tool to reduce HIV risk, some seronegative respondents in my research were utilising it as a means of rejecting seropositive partners, thereby reinforcing HIV stigma in the communities. This reflects findings by Stirratt (2005) who found that sexual rejection was the primary form of HIV stigma experienced by seropositive men. However, the seronegative

respondents in my research were unclear about the most appropriate stage for seropositive men to disclose, further complicating the challenges for seropositive men in the disclosure process. Therefore, opportunities to negotiate HIV risk with seropositive partners who had an undetectable viral load were being lost because of a lack of knowledge and the difficulties presented by HIV stigma in the disclosure process.

Many of the respondents in my research acknowledged the impact of negotiating condom use immediately prior to sex, reflecting the findings of Holland et al. (1998). These respondents felt that a discussion of condom use immediately prior to sex could potentially impact on the sexual situation and therefore were reluctant to engage in such conversations. Some of these respondents felt that their receptive role in sex influenced their ability to assert a desire for safer sex, as to discuss condom use was interpreted as a challenge the active partner's implicit dominant role, concurring with the findings of McInnes et al.'s (2011). In line with Delph's (1978) research, this inability to communicate a desire for safer sex was also stressed by my respondents who engaged with the more anonymous sexual cultures, such as cruising areas. Although over thirty years have passed since Delph's research, my research has indicated that a code of silence is still embedded in modern anonymous sexual cultures used by MSM. This is particularly concerning given that some active/versatile respondents in my research also interpreted non-verbal communication of a desire for safer sex as assent for bareback sex, reflecting the findings of Adam et al. (2008). As a result of these miscommunications, some men could be placing themselves at increased risk of HIV acquisition because of their inability to communicate a desire for safer sex in certain sexual situations.

Mowlabocus (2010) and Avery (2013) have both pointed to the popularity of dating sites and mobile phone applications in the MSM communities. Indeed, many of my respondents were

accustomed to the content and the techniques of understanding serostatus from the mock profiles used in the survey. This was particularly the case for the term 'safer sex only', which many respondents used to identify the profile owner as seronegative. The omission of the term from another profile was also detected by respondents, suggesting the importance of this term for understanding serostatus on profiles. However, similar to the findings of Adam (2005), there were different understandings of the term between seropositive and seronegative respondents to my survey. While seropositive respondents used the term to indicate the importance of safer sex to protect any potential partners, seronegative respondents felt that it implied the owner of the profile had safer sex all the time and was therefore also seronegative. However, a number of seropositive respondents also used the term 'safer sex only' to indicate their seropositivity on their profiles. This disparity in the interpretation of the term 'safer sex only' indicated a difficulty for men, particularly when online profiles were used to serosort for partners. This could potentially expose men who rely on the term for interpretation of serostatus to HIV without their knowledge.

In line with Stirratt (2005) and Hoff and Kamchikanti (2002), my research found that while normative cues were also being used by both seropositive and seronegative respondents to indicate their individual serostatuses in the 'real' world, seropositive respondents were more likely to report their use. However, my research also revealed that both seropositive and seronegative men used the same cues to indicate their varying serostatuses. This was particularly the case for the phrase 'there is no need for condoms with me'. As different understandings were attached to the same allusion, respondents who had serosorted for partners of the same serostatus may have unintentionally exposed themselves/others to the HIV virus. However, given that Ridge et al. (2007) has indicated that seropositive men wish to reveal their serostatus to partners, it is perhaps that they are more aware that they are engaging

in allusions than seronegative men. Therefore, while seropositive men might be more likely to report using allusions, it is possible that seronegative men are also using them, but remain unaware of their use. This points to a need for further research on this topic.

If one was unsure of a partner's serostatus after attempts to decipher cues and allusions, there was an opportunity for them to engage in a one, or more, risk reduction strategies to minimise potential HIV risk. My research indicated that the most commonly utilised risk reduction strategy was serosorting, which Rowniak (2009) described as the practice of choosing to have bareback sex with someone of the same *known* serostatus. However, given the potential confusion that could arise from misreading a profile and/or allusion discussed above, questions about whether or not respondents knew their partner's serostatus are raised. In addition, serosorters are encouraged to have HIV tests every three-months, given that they have engaged in risky sex. However, my findings revealed that only twelve percent of serosorters tested for HIV every three months. A further third did not test at the minimum recommended testing cycle (yearly) and a number never tested for HIV. This suggests that those who believed they were serosorting were likely to be seroguessing, which Zablotska et al. (2009) described as the practice of choosing to have bareback sex with someone of *assumed* same serostatus. This placed these men at increased risk of HIV acquisition when they believed they had taken active steps to minimise such risk. This points to a need for increased awareness within the communities about the differences between serosorting and seroguessing and importance of regular HIV testing for those engaging in high-risk sexual activity.

Summary & Discussion

It was evident from my research that seropositive respondents believed in the notion of mutual responsibility in the disclosure process and that they should not be wholly responsible for

protecting others from acquiring HIV. It was possible that seropositive men had greater awareness of the considerably reduced risk they pose to seronegative men when they have an undetectable viral load and that such information should be disseminated more widely in the seronegative communities. However, it was also evident that seronegative men felt that seropositive men had more responsibility to disclose their serostatus and often presumed that other men were seronegative unless otherwise informed. Therefore, it is clear that seronegative men need greater knowledge of the HIV risk from seropositive men with an undetectable viral load. This information may also reduce the expectation that a seropositive partner will disclose their serostatus automatically. However, seropositive men should be aware that seronegative men may also have a different understanding of the disclosure process to them, so that both of the sero-communities understand their role in the disclosure process.

HIV stigma played a crucial role in seropositive men's decisions about disclosure, as they feared rejection from seronegative partners. While many seronegative respondents in my research stated that disclosure would enable them to make informed decisions about HIV risk, some admitted they would use such information as a means to exclude seropositive partners. Therefore, even though seronegative men felt that seropositive men should disclose their serostatus, they had used this disclosure as a means of rejecting a partner on its basis. As a result, these seronegative respondents reinforced HIV-stigma, which was likely to increase seropositive men's reluctance to disclose. While seropositive men need to be made aware that many seronegative men have an expectation that they will be informed of a partner's seropositivity, seronegative men also need to be made aware of the impact of rejection and how this contributes to, and reinforces, HIV-stigma and justifies non-disclosure. Therefore, it is evident that both communities need to be aware of each other's expectations around disclosure

and that techniques for dealing with disclosure are needed to reduce the established HIV-stigma in the communities.

It was clear that some respondents felt that there was a certain point at which they felt it was too late to discuss condom use for fear of the impact it may have on the sexual situation. This suggests that respondents felt there was a point at which they felt that they could not speak about safer sex with their partners. It was clear that these men did not have the necessary skills to discuss condom use, particularly during moments of sexual intensity. Therefore, it is necessary to ensure that all men have the appropriate negotiating skills that will make them confident in their approach to condom use, particularly during moments of sexual intensity.

However, there were certain situations; such as when respondents were in the receptive role or when in anonymous sexual cultures, that respondents felt it was inappropriate to discuss condom use. This indicates that men, particularly when they are in the active role, need to be encouraged to play an equal role in discussions about safer sex. Therefore, the challenge is not solely to encourage men to speak about condom use, but also for them to ask about a partner's preference for condoms, particularly when they do not raise the issue of condom use. This approach would challenge men to take into consideration not only their own preferences for condom use, but also their partner's preferences parallel to this. Therefore, responsibility will not lie with one partner alone, but between both partners together, which may decrease the likelihood of silence being equated with assent for bareback sex.

The growth of MSM internet dating sites/apps means that they are likely to be the first point of filtering of serostatus for many MSM. Indeed, respondents showed familiarity with the structure

of the mock profiles and engaged with them to understand serostatus. While respondents in my survey used online profiles as a means to decipher serostatus, distinctive understandings were applied to different allusions in profiles according to serostatus. This was most notable with the term 'safer sex only', which the vast majority of respondents associated with seronegativity, while its absence was linked with seropositivity. Similar potential misunderstandings were noted in allusions used to filter in the 'real' world. Therefore, it is imperative that cues and allusions used in both the online and 'real' world be challenged, so that men realise that they are not a reliable way to interpret serostatus. Otherwise, such cues to serostatus will continue to be misunderstood, with the greatest impact being on serosorters who do not explicitly disclose their serostatus to other men.

If respondents were unclear about serostatus, there was an opportunity for them to engage in a variety of risk reduction strategies. The most commonly used strategy utilised by seronegative respondents was serosorting. However, it was clear that the majority of serosorters were not testing at the appropriate testing cycle for those engaging in high-risk sexual behaviours, with a number having never tested or had not tested to the minimum recommended testing cycle. There were two possible explanations for this; seronegative men who engage in serosorting were not aware of this recommended testing cycle, or they were not interpreting their behaviours as risky. In either case, it is evident that seronegative men need to be made more aware of the importance of regular testing when serosorting. In addition, these men need more understanding of the window period in HIV testing and its potential impact on serosorting.

While respondents to my survey were largely negative towards PrEP as a potential risk reduction strategy, opinions may have changed since the more recent success of the PrEP trials and the increased media discussion about PrEP following the High Court ruling against the NHS (Cairns

& Pebody, 2016). Creating more positive awareness of these trials may lead to increased awareness of PrEP within the communities making it more acceptable to men most in need. The promotion of PrEP in a positive manner is particularly important given the 'PrEP-whore' shaming discourse that surrounds the drug in the United States (Spieldenner, 2016) and which has been identified in this research.

Conclusions

The title of this thesis was 'How do MSM currently understand, evaluate and respond to HIV risk?'. Overall, the findings indicated that MSM's understandings of their risk of HIV infection were evolving with many believing that their risk was considerably lower than that presented by experts in the field. While this may have been considered a reflection of treatment optimism (Elford et al., 2000; Kelly et al., 1998), many respondents did not have an understanding of the developments in antiretroviral treatment and the potential impact this has on HIV risk. The associations made between HIV and death, the reluctance of respondents to have sex with men they knew to be seropositive and the lack of engagement with viral-sorting all indicated a lack of knowledge about antiretroviral treatment. Therefore, in line with the findings of Kalichman et al. (2007) and Dukers et al. (2001), treatment optimism can be disregarded as an explanation for why many of my respondents had a different understanding of HIV risk differently from experts.

Since the early part of the twenty-first century, the normalisation project (Neary, 2014) has given rise to a 'good gay' discourse (Bell & Binnie, 2000) in increasingly homonormative MSM communities. This new discourse significantly muted the masculine, transgressive discourses

that was identified by Dean (2009), Ridge (2004) and Schilder et al. (2008) in previous research. The result of the dominance of the 'good gay' discourse in my research was that new hierarchies (Butler, 2002) between legitimate actors and *illegitimate others* were becoming embedded in these communities. This was reflected in the strong moral discourse that emerged in this research. However, while respondents were *othering* men (Douglas, 1985; Joffe, 2003) for being *illegitimate*, they were also engaging in, but importantly did not see themselves as embodying, this *illegitimate* behaviour. This process of *othering* was significantly different from previous *othering* discourses, which stemmed from a variety of biomedical advances (Flowers, 2001; Botnick, 2000; Johnston, 1995). As a result, it was important for men to appear as legitimate actors and engage in strategies of exclusion of *illegitimate others* (Wilkinson, 2006), even when they were engaging in *illegitimate* behaviours. It was argued that respondent's understandings of HIV risk also stemmed from the comparisons they were making between their own behaviour and that of the imagined *illegitimate other*. Therefore, the real risk-takers were the *illegitimate others* and, as the respondents did not embody the *illegitimate*, they could either minimise the extent of their own risk-taking, or not believe themselves to be at risk of HIV infection in comparison to these *others*. As a result, I am suggesting that HIV risk understanding is becoming embedded in these hierarchies of legitimacy and affecting how men understand their risk of HIV infection at the current time. Therefore, my respondents were no longer solely comparing their own risk behaviours with the advice of experts, but also against those they understood to be the *illegitimate others*. Comparisons with an imagined *illegitimate other* were likely to depict the respondents own high-risk behaviours in a more favourable manner than in comparison with information from experts. Therefore, it is conceivable to suggest that respondents were assessing their high-risk behaviours by comparison with *illegitimate others* than with experts.

The impact of the 'good gay' discourse was also represented in respondents' favourable opinions of monogamy and the fact that they were less likely to identify their relationship as 'open' than in previous research (Hickson et al., 1994). However, the definition of monogamy was more fluid than traditional interpretations, which was similar to the findings of Shernoff (2006a) and some respondents in 'monogamous' relationships had sex with other men while also feeling committed to their primary partner (Blasband & Peplau, 1985). This suggests that the definition of monogamy for these men was something beyond sexual monogamy. Open relationships were based upon notions of compartmentalisation (Bonello, 2009), but my research found that intimate sex was particularly important for the maintenance of respondents' open relationships. This suggests that the separation of sex and emotions was more complicated than Bonello (2009) suggested. In addition, my research indicated that relationship agreements were likely to be implicit rather than explicit. However, respondents in open relationships felt that their relationship structure was more honest than these 'monogamous' relationships, which was similar to Adam's (2006) research. However, my findings revealed that respondents in open relationships were as likely as those in 'monogamous' relationships to break an element of their relationship agreement. Therefore, while open relationships were considered more honest and therefore more likely to decrease the possibility of HIV transmission within the primary couple, my research indicated that complex nature of open relationships implied that this was not always the case.

How men negotiated sex was of particular importance to this research. It was evident that seropositive men were reluctant to disclose their serostatus to other men because of HIV stigma (Ridge et al., 2007) and the reduced risk they posed to seronegative men with the advancement of new treatment technologies. This was a marked shift in opinion since Wolitski et al. (2003), who found that a majority of their seropositive men felt it was their responsibility to disclose.

However, it was also clear that many of my seronegative respondents in my research expected a seropositive partner to disclose their serostatus prior to sex, suggesting that seronegative men did not feel the need to discuss their serostatus with others (Flowers et al., 2000). This suggests that both seronegative and seropositive respondents had different understandings about disclosure, which was likely to increase the possibility of HIV transmission, particularly if the seronegative partner was serosorting. Therefore, while disclosure of serostatus could be used as a powerful tool to reduce HIV risk, it was clear that seronegative men felt that it was the responsibility of a seropositive partner to disclose, while HIV stigma influenced seropositive men's desire to disclose. As a result, while disclosure could be used as a powerful tool to minimise HIV transmission, opportunities for disclosure were being lost for a variety of reasons.

It was evident that some respondents felt that they were unable to discuss condom use with partners. These included times when my respondents were in the passive position (McInnes et al., 2011) and in anonymous sexual cultures (Delph, 1978). This was particularly concerning as Adam et al. (2008) found that non-verbal communication of a desire for safer sex was often taken as assent for bareback sex. However, it was also clear that many respondents tried to understand serostatus from profiles on dating sites and mobile phone applications. While 'safer sex only' was the most common way for respondents to identify a profile owner as seronegative, it was evident that both seronegative and seropositive respondents had dissimilar understandings of the term. Equally, cues to serostatus in the 'real' world were also interpreted differently by seropositive and seronegative respondents. Therefore, it is evident from my research that while cues and allusions to serostatus were routinely used in the MSM communities, misunderstandings were also common. This was particularly important if a seronegative man was trying to serosort for partners using cues or allusions, as the likelihood of misunderstanding may increase the possibility of HIV transmission in such encounters.

The most frequently used risk-reduction strategy by my respondents was serosorting (Rowniak, 2009). However, it was clear that seronegative men who were engaging in serosorting were not testing at the appropriate cycle for men engaging in high-risk sex. Indeed, some of these respondents had never tested for HIV. This suggests that many respondents who believed that they were reducing their risk of HIV acquisition were in fact seroguessing (Zablotska et al., 2009). Rather than reducing their HIV risk, respondents who were engaging in seroguessing were increasing their possibility of HIV acquisition. It was evident that while my respondents held largely negative views of PrEP as a potential risk reduction strategy, they felt that men were more likely to take the drug if it became more widely available on the NHS. However, many of my respondents spoke about PrEP in strong moral terms, suggesting that the drug was more appropriate for *illegitimate others* than themselves. This indicated that the 'PrEP-whore' discourse identified by Spieldenner (2016) in the United States may be evolving in the UK. However, it should be noted that PrEP is an evolving field and opinions may have changed because of the more positive results that have emerged from the recent trials (Molina et al., 2015; Punyacharoensin et al., 2016). In addition, increased PrEP awareness was likely to have been a result of the press coverage of the NHS' initial refusal to fund PrEP (Cairns & Pebody, 2016). These developments are likely to have significantly impacted upon men's opinions about PrEP, which further research is likely to reveal.

These results raise some important points that could be used in conjunction with some the established interventions already used by sexual health promoters (Hickson, 2011) discussed in chapter nine. These include small structured group interventions, which have proven effective for behavioural change (Hickson, 2011). To assist couple make explicit relationship agreements, relationship counselling may be offered those entering new relationships. Internet-based interventions, which may help to increase sexual knowledge, may be particularly useful for

targeting men who make use of internet sites and/or mobile phone application to seek other men. However, as discussed in the discussion chapter, questions have been raised about the effectiveness of such interventions (Nutland, 2015). Challenging homonormativities and attitudes towards PrEP require interventions that can reach a wider number of people. Social diffusion interventions and media advocacy may assist with challenging homonormativities (Duggan, 2002) and the potential consequences that *othering* may have on sexual health. Given the importance of PrEP to the sexual health field at the current time, greater media advocacy and community education may help to increase awareness of PrEP, while one-to-one or small group interventions may be used for high-risk men who may benefit from using PrEP. While many of these interventions may be already established (Hickson, 2011), these results reveal that a slight change in the aims of some of these interventions may be required to relate them to the issues raised by this research. However, given the range of interventions suggested, it may be that they could be integrated into one overall multi-level intervention to achieve change at different levels (Cragg et al., 2015). However, as with the implementation of any health promotion intervention, prioritisation and budgeting, particularly in a time of austerity, is likely to impact on any future sexual health intervention (Nutland and Cragg, 2015).

This thesis sought to explore how MSM in the UK currently understand, evaluate and respond to HIV risk. The findings revealed how shifting definitions of sex, which have resulted from developments in biomedical prevention technologies, and love, as a result of the new relationship structures available to MSM, are affecting how men understand HIV risk. They have also explored how MSM evaluate and respond to HIV risk and suggest improvements that may address these issues.

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AIDS:

Acquired Immunodeficiency Syndrome. A disease of the immune system, which is fatal unless otherwise treated.

AZT/ZDV:

Azidothymidine, also known as Zidovudine: The first antiretroviral drug for HIV, which reduced, but did not stop the replication of the virus. However, resistance to AZT often build up over time making it ineffectual over the long term.

Bareback Brotherhood:

The Bareback Brotherhood is a worldwide online social group who promote and endorse barebacking as a legitimate choice. It had been widely criticised for promoting bareback sex, particularly among those who are impressionable.

Barebacking:

Barebacking refers to condomless anal intercourse – a practice that has become increasingly common among MSM (Eaton et al., 2009). Receptive bareback sex carries the highest risk of HIV acquisition (Paz-Bailey et al., 2013) and therefore is a concern to sexual health promoters. More recently, Dean (2015, 225) has differentiated between bareback and raw sex, in which raw sex ‘bears some of the same erotically charged connotations as bareback, but without the stigma’. Although consideration was given to the term ‘raw sex’ in this work, the term bareback is used. In this thesis, I use the term barebacking to refer to all those who engage in unprotected anal sex.

Barebacker:

A barebacker is someone who intentionally engages in bareback sex. However, many men who engage in bareback sex may not necessarily identify as barebackers. Speaking about

barebacking and identity in the United States, Dean (2015, 230, emphasis his own) highlights this difference when he states that ‘the extent to which bareback has become a ‘lifestyle’ exacerbates the disjunction between how individuals...self-identify and how they are categorised by epidemiologists’. For the purposes of this research, a barebacker is someone who engages in bareback sex, whether or not they self-identify as such.

Barebacking subculture:

A subculture made up of men who *intentionally* seek bareback sex with other men. While many of these men are seropositive, seronegative men also belong.

BDSM:

Bondage, Domination, Sadism, Masochism (BDSM). A type of sexual fetish enjoyed by men and women of all sexualities.

Berlin Patient:

Timothy Ray Brown (a.k.a. ‘the Berlin Patient’) was seropositive when he was given a blood stem cell transplant for leukaemia in 2006. The donor for this operation had a rare form of gene mutation that was resistant to HIV. Since the operation, Brown has not taken any antiretrovirals and has undergone many HIV tests, all of which have been seronegative. The costs and risks involved in such a transplant and the rarity of the gene mutation means that this is not a practical solution for the cure of HIV/AIDS generally.

‘Breeder’:

A breeder is a primarily derogatory term used to describe someone who ejaculates inside another during anal sex without a condom. However, the term is embraced by some in the bareback community.

‘Bug-Chasers’:

‘Bug-chasers’ are seronegative men who deliberately seek out seropositive partners in order to become infected with HIV (Dean, 2009). However, there is a debate about whether or not ‘bug-chasers’ exist beyond an online fantasy (Grov & Parsons, 2006) and about the significance of their number (Tewksbury, 2003).

Communities:

The term *communities* is used by sociologists to emphasise the diversity of sexual cultures in what has been traditionally known as the gay *community* (Wilkinson et al., 2012). Significant variation occurs in terms of gender (Connell, 1992), ethnicity (Han, 2007), class (Barrett & Pollock, 2005), neighbourhood (Mills et al., 2001) and if one defines as bisexual (Balsam & Mohr, 2007). Other theorists have placed importance of the differences between *community connectedness* and *community participation* (Frost & Meyer, 2012).

Condom Code:

The ‘condom code’ is the use of condoms for all forms of sexual contact to hinder the spread of HIV and was first endorsed by the MSM communities in the early-1980’s, prior to medical advice becoming available.

Cruising:

Searching for an anonymous sex partner by driving or walking in certain areas.

Cub:

A young hairy man, who usually socialises in the wider ‘bear’ (hairy men) communities.

Fingering:

The insertion of finger/s into the anal passage for sexual stimulation. It is often used as a prelude to anal sex and is usually carried out by an active partner.

Gaydar:

Gaydar (www.gaydar.co.uk) is one of the most popular IRC internet sites for MSM in the UK. It gains revenue from subscriptions (although limited free membership is available) and directed advertising.

GRID:

Gay-Related Immune Deficiency. One of the earliest terms used to describe HIV/AIDS prior to the virus being isolated.

Grindr:

Grindr is a commonly-used location-based mobile phone application that arranges men in order of distance from the subscriber's current location and facilitates text contact between members.

HAART:

Highly Active Anti-Retroviral Treatment. Combination therapies used to combat the progression of HIV.

HIV:

Human Immunodeficiency Virus; the virus which causes AIDS.

MSM:

Men who have Sex with Men. While seen by some as an inclusive term, it has been widely criticised as it 'obscures social dimensions of sexuality, undermines the self-labelling of...gay and bisexual people and does not sufficiently describe variation in sexual behaviour' (Young & Meyer, 2005, 1144). Nevertheless, it is used in this thesis to allow for accurate comparisons with previous literature.

PEP:

Post-exposure prophylaxis – a biomedical prevention intervention used by seronegative men *after* exposure to HIV (Omrani & Freedman, 2005). Similar to PrEP (explained below), PEP makes use of antiretroviral drugs to halt the progression of the virus within the body.

‘Poppers’:

A slang name for amyl nitrates, which are inhaled and often used to relax the splinter muscles during anal sex.

PLHA:

Person/People living with HIV and AIDS

PrEP:

Pre-exposure prophylaxis – ‘a pharmaceutical strategy that involves the use of antiretroviral drugs by HIV-negative individuals for HIV prevention’ (Race, 2015, 6). While similar to PEP, PrEP is taken *before* any potential exposure to HIV and is meant to be taken only while an individual is at risk of becoming infected.

Risk Reduction strategies:

Much literature has been produced on the various steps men who engage in bareback sex take to minimise chances of HIV infection, known as risk reduction strategies. (Rowniak, 2009; van den Boom et.al. 2012; Zablotska et.al. 2009). These steps differentiate barebackers from ‘bug-chasers’, as they actively seek infection.

- **Negotiated Safety:**

Negotiated safety is a term used for couples who agree to have safe sex in any extra-dyadic encounters while continuing to have bareback sex together. This has significant implications for the reduction of HIV transmission within the primary couple (Halperin, 2007; Rowniak, 2009)

- **Serosorting:**

Serosorting is the practice of choosing to have unprotected sex with a partner of the same *known* serostatus (Rowniak, 2009). While successful with seropositive men who explicitly disclose their serostatus, ‘the efficacy of serosorting in reducing the risk of HIV transmission in HIV-seronegative gay and bisexual men remains far inferior to consistent use of condoms’ (Blackwell, 2015, 560).

- **Strategic Positioning:**

A risk reduction strategy that involves the act of deliberately taking the active role in anal sex in order to minimise the risk of HIV infection (Suarez & Miller, 2001).

- **Viral-sorting:**

The practise of a seronegative man deliberately choosing a sexual partner who is seropositive and has an undetectable viral load as a means of risk reduction (Jin et al., 2015).

- **Withdrawal:**

The practice of withdrawing the penis from the chosen orifice prior to ejaculation, as a means of risk reduction. Commonly used by heterosexuals as a means of reducing risk of pregnancy, it can also be used to prevent semen entering an orifice to reduce the possibility of HIV transmission. However, this method fails if pre-ejaculatory fluids remain in the orifice.

Section 28:

Section 28 of the Local Government Act 1988 stated that ‘a local authority shall not (a) intentionally promote homosexuality or publish material with the intention of promoting homosexuality; (b) promote the teaching in any maintained school of the acceptability of homosexuality as a pretended family relationship’ (cited in Bell & Cumper, 2003, 215).

Semen exchange:

The practice of orally, vaginally or anally ingesting semen in the course of sex.

Seroconcordant:

Seroconcordant partners are those who are both of the same serostatus.

Serodiscordant:

Serodiscordant partners are those with one seropositive and one seronegative partner.

Seroguessing:

The practice of choosing to have unprotected sex with a partner of *assumed* same serostatus.

(Zablotska et al., 2009)

STIs:

Sexually Transmitted Infections; may also be referred to as STDs, Sexually Transmitted Diseases.

For the purposes of consistency, I only use the term STIs in this work.

TasP:

Treatment as Prevention. The use of antiretroviral drugs in the seropositive communities as a means of preventing other people from acquiring HIV. There was been a recent push for people who have seroconverted to be treated when they are diagnosed, rather than wait for a reduced CD4 count.

Twink:

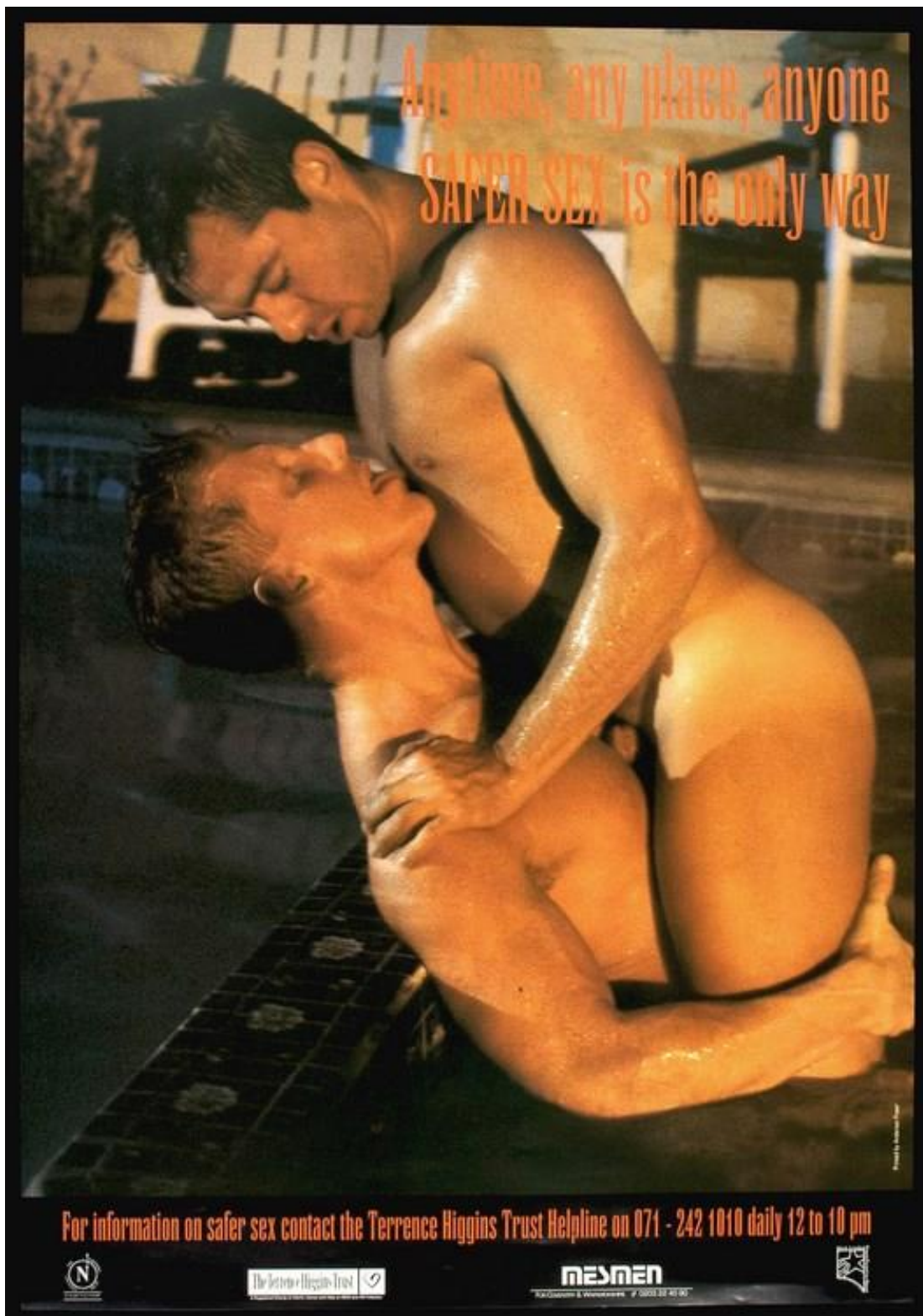
A young gay man, many of whom are quite camp in nature and usually socialise in places with other men in the same category.

VISCONTI Trial:

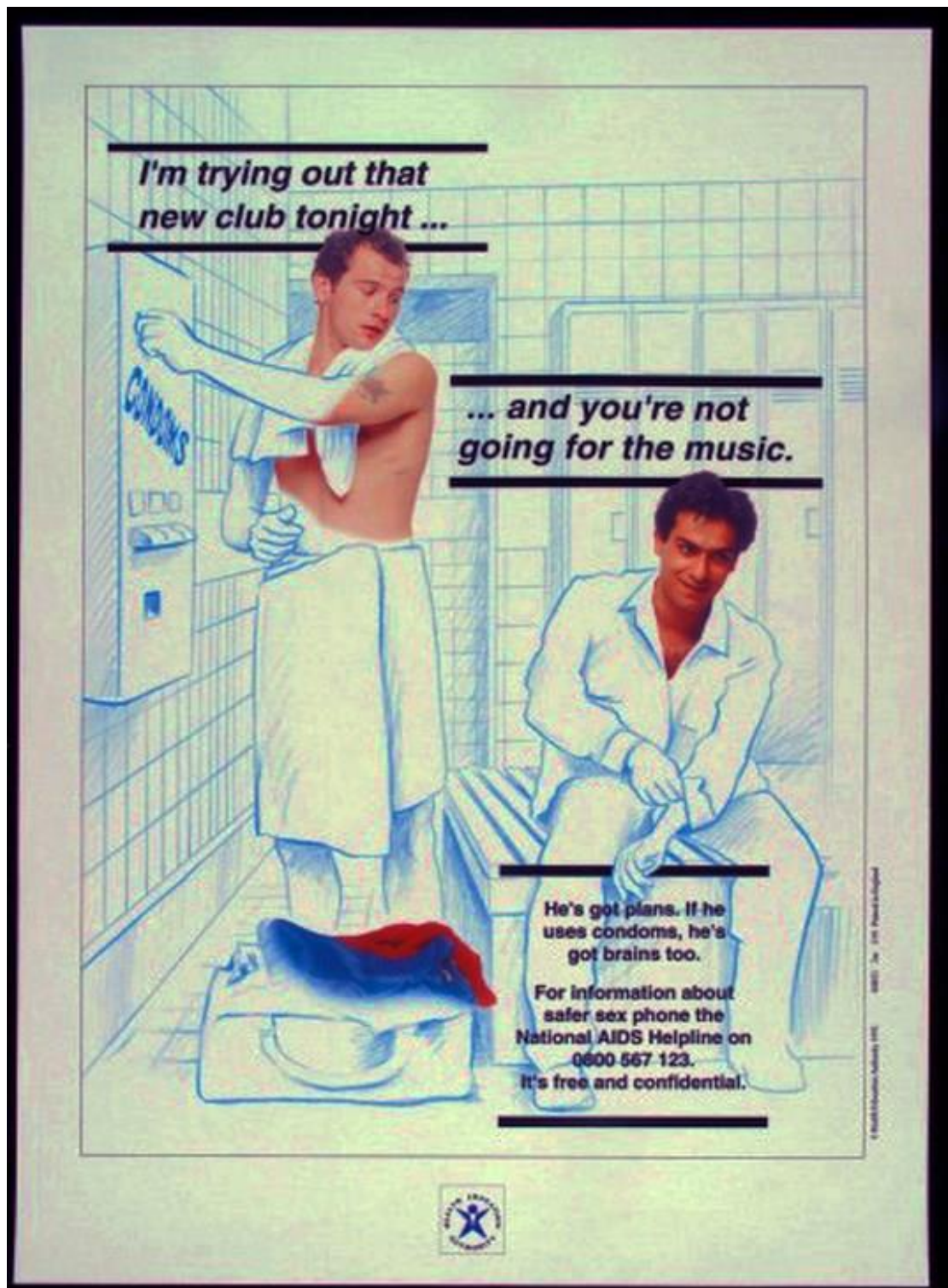
Viral-Immunologic Sustained Control after Treatment Interruption. A small scale French research project involving 14 seropositive adults who begun antiretroviral treatment within ten weeks of seroconversion and continued for a period of three years, after which they stopped treatment. While patients have low HIV detectability in their blood, they have not developed AIDS after seven years of non-treatment (Lopez, 2013).

Appendix One – Mass Media Interventions

- I. Anytime, any place, anyone



II. I'm trying out a new club tonight



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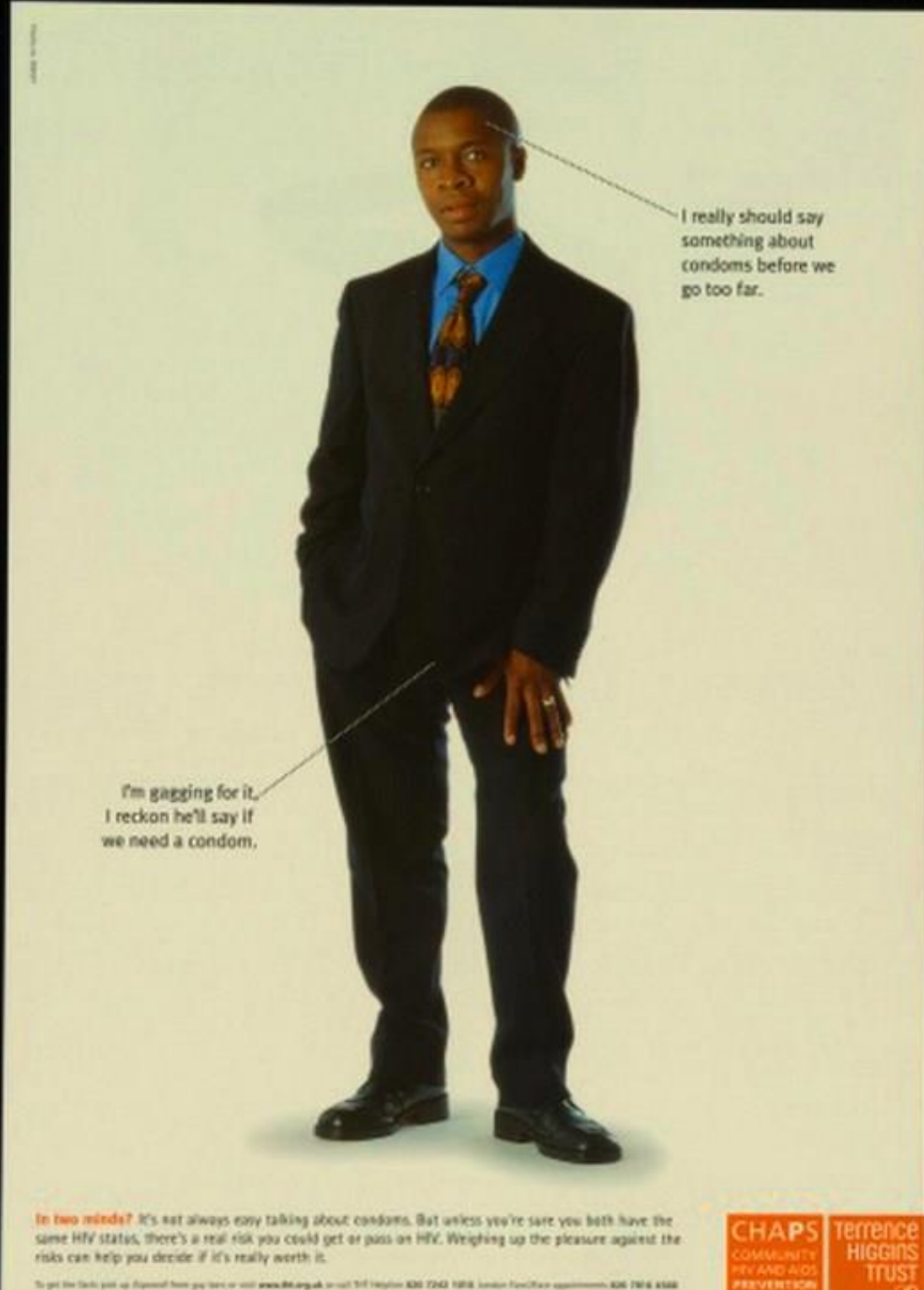
III. The Tombstone



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IV. I really should say something about condoms...



I really should say something about condoms before we go too far.

I'm gagging for it. I reckon he'll say if we need a condom.

In two minds? It's not always easy talking about condoms. But unless you're sure you both have the same HIV status, there's a real risk you could get or pass on HIV. Weighing up the pleasure against the risks can help you decide if it's really worth it.

To get the facts pick up a packet from gay bars or visit www.tht.org.uk or call 011 744 1010. London Free/Office appointments: 020 7916 6166

CHAPS
COMMUNITY
HIV AND AIDS
PREVENTION
STRATEGY

**Terrence
HIGGINS
TRUST**

V. It starts with me



WE CAN STOP HIV
Treatment can stop HIV being passed on. But thousands have HIV and don't know it.

*It's time
I tested*

IT STARTS WITH ME

terrence HIGGINS TRUST Together testing, treatment and condoms can stop HIV.
Order your free postal HIV test or find a clinic:
StartsWithMe.org.uk  startswithme  @startswith_me

Produced by Terrence Higgins Trust for HIV PREVENTION ENGLAND. Terrence Higgins Trust is a registered charity in England and Wales (reg. no. 1084123) and in Scotland (SC030866).

Appendix Two – Mock Profiles

I. *Hungasahorse*

Hungasahorse

I am:

Bi-sexual

Position:

Top Only

Looking for:

1-to-1 sex; relationship

Into:

Twinks, Builders, Muscle men

Fetishes:

Armpits, Cut, Dmin, Underwear,
Speedos, Muscle

Likes:

Safer sex only, Oral, Anal, Rimming,
Wanking, Vanilla, Kissing.



Picture adapted from © See-Ming Lee, <http://creativecommons.org/licenses/by/2.0/>

II. *Anytimebloke*

Anytimebloke

I am:

Single Gay Man

Position:

Versatile

Looking for:

Relationship, 1-on1 sex,
Group sex, Friends

Fetishes:

Anal, Armpits, Nipples,
Body hair, Piercing, Uncut,
Kilts, Saunas

Likes:

Anal, Oral, Kissing, Vanilla,
Groups



Picture adapted from © Postbear, <http://creativecommons.org/licenses/by/2.0/>

Appendix Three – Comparison of Men

I. Image A and Image B

Image A:

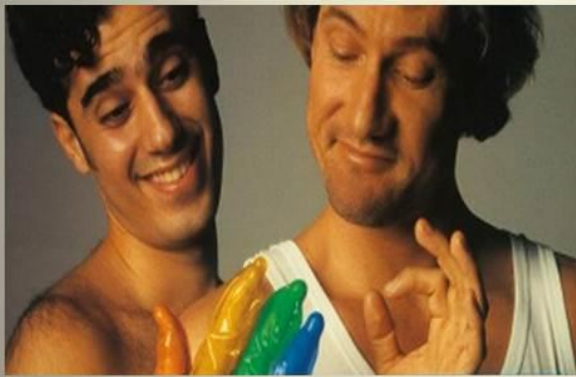


Image B:

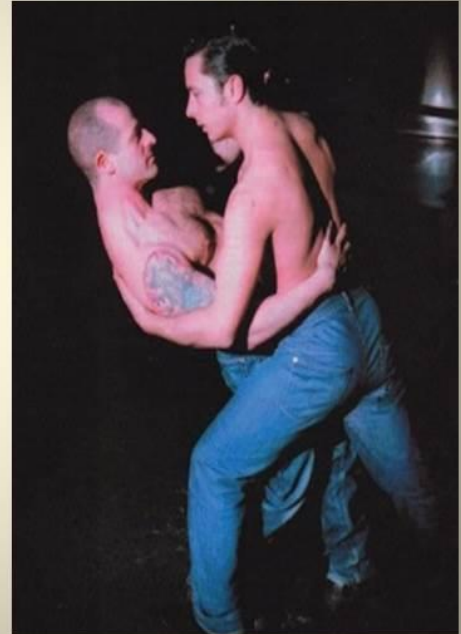


Image A: Picture adapted from © Crown Copyright and Department of Health.

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Image B: Picture adapted from © Gay Men Fighting AIDS.

<http://www.gmfa.org.uk/>

Appendix Four - Vignette

Part One

Juan is HIV negative and has arrived in London after spending the first twenty-five years of his life in a religiously conservative country where to be gay is considered unacceptable. When he arrives in London, he is alone for the first time and wants to explore the more liberal aspects of gay London life. He's thrilled to discover places where men openly and freely fuck without shame. He loves London's saunas, darkrooms and sex clubs, but notices that only some men use condoms. On several occasions he has been rejected by a number of men for insisting they use condoms. Seeing how easy it is for other guys to have sex without condoms, Juan thinks that it will be less hassle and he will be more popular if he chooses not to use condoms, but knows the risks involved.

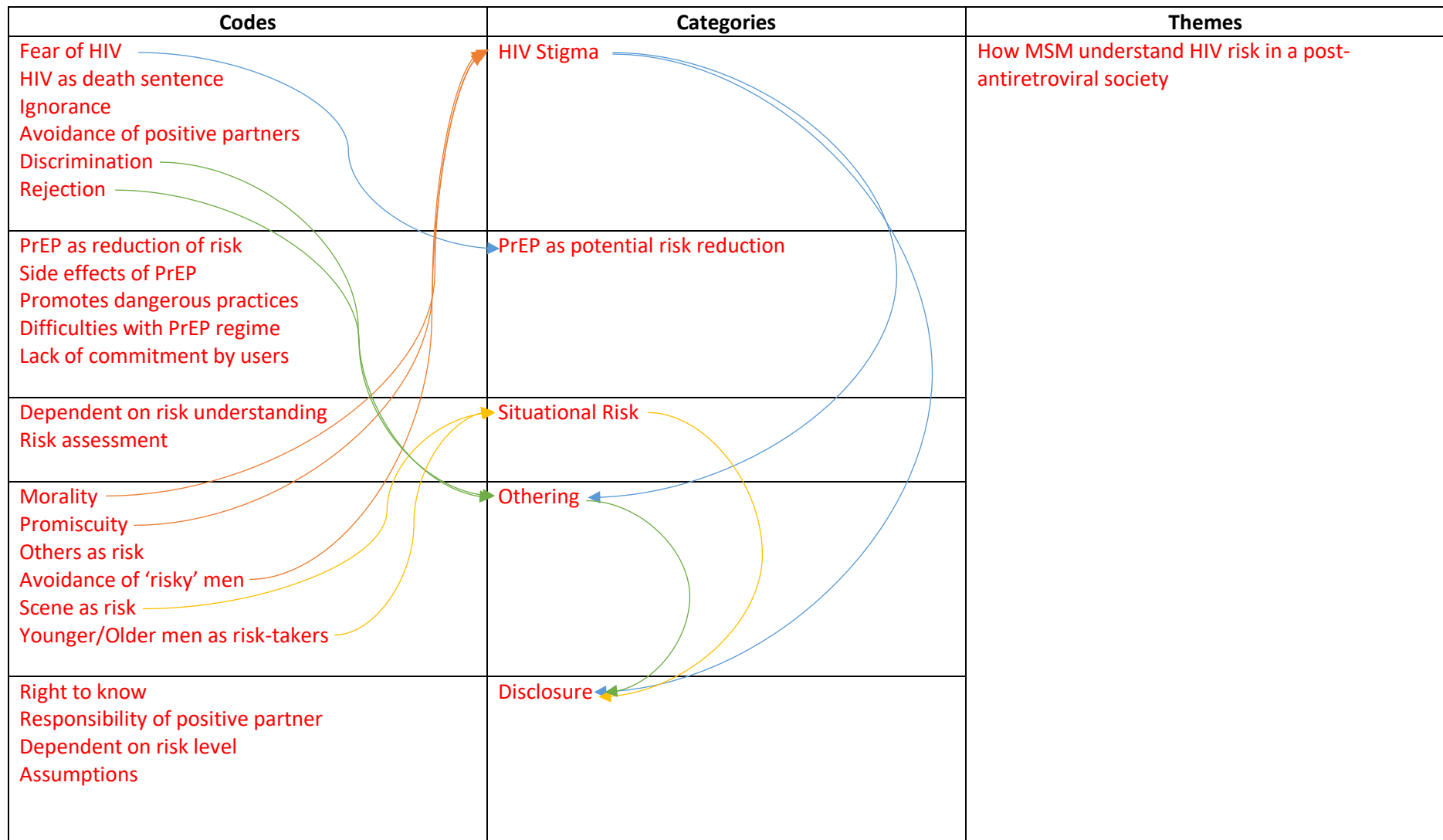
As a friend, what would you say to Juan about his dilemma between being popular in the clubs and his condom use?

Part Two

Juan often chats to men after sex. It is during this time that he finds out that a lot of the men are HIV-positive. He's shocked, as many of these men look fit and healthy and contradict the images he had of HIV-positive men. They also seem to know how to enjoy their sex lives without the worry of catching HIV. As time goes on, Juan begins to consider that HIV positive men have a better life than he ever realised. From his perspective, they take a few pills every day, tend to have amazing bodies and can have sex with whoever they want without having to worry about condoms or catching HIV. He decides that acquiring HIV is not such a big deal and from this point onwards is not as insistent about using condoms as he once was.

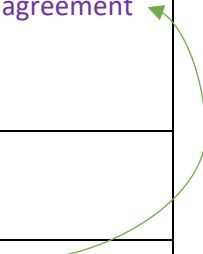
What do you think about Juan's reasoning and his decision not to use of condoms?

Appendix Five – Qualitative Codes and Themes



<p>Cruising</p> <p>Impact of speaking about condoms</p> <p>Misunderstandings with allusions</p>	<p>Disclosure (cont.)</p> <p>Non-verbal negotiation</p>	<p>How MSM negotiate sex prior to, and at the point of sexual engagement</p>
<p>Profile reading</p> <p>Lie on profiles</p> <p>Safer-sex included/excluded</p> <p>Sex/relationships</p> <p>Sexual Role</p> <p>Appearance</p> <p>Username</p> <p>Bisexuality</p>	<p>Importance of reading serostatus from profiles</p>	
<p>Guess</p> <p>Committed to safer sex</p> <p>Committed to bareback sex</p>	<p>Outcomes of negotiation process</p>	
<p>Alcohol/drug use</p> <p>Horniness</p> <p>Being receptive</p>	<p>Influences on control to make decisions</p>	
<p>'Masculine-looking' sex</p> <p>Semen as masculine</p>	<p>Risk-taking as masculine</p>	<p>How masculinities inform HIV risk and response</p>
<p>Blurred monogamy</p> <p>Assumed agreements</p> <p>Agreements not clearly defined</p>	<p>Implicit agreements about sex with other men</p>	<p>How informal/formal relationship agreements impact on HIV risk</p>

Fell in love Slept with people not supposed to Safer sex	Likelihood of telling partner if broke agreement	
LTR sex as safe Intimacy	Importance of intimacy in LTRs	
Monogamy as honesty Monogamy as okay for others	Variation in definition of monogamy	



Appendix Six – List of Quantitative Variables used in Analysis

The following is a list of all variables used in the survey according to appearance in the findings chapters. On first mention, all variables include a question number, which indicates the question number on the survey. However, responses to questions may have been recoded and therefore the number of responses may differ from those listed in the survey. For example, in the age question on the survey, there was nine options for respondents. However, as numbers in the older age categories were too small to make any analysis meaningful, the three separate categories (51-60; 61-70; 71+) were collapsed into one new category (50+). Those who were '17 or under' were disqualified from the survey and one respondents opted for 'rather not say'. Therefore, of the original nine options presented to respondents, only five appear in the final analysis.

Chapter Five

Age of respondent (Q 10)

Country of UK lived in (Q 3)

Description of area lived in (Q 4)

City or town location (Q 5)

Born in UK? (Q 11)

Ethnicity of Respondent (Q 6)

Sexual attracted to? (Q 14)

Term used to describe sexuality (Q 15)

Sexual role of respondent (Q 16)

Drinking habits of respondent (Q 19)

Drug use of respondent (Q 20)

Type of drug used by respondent (Q 21)

Drug use with alcohol/other drugs (Q 22)

Perceived effect of alcohol/drug use on decision-making (Q 23)

Serostatus of respondent (Q 27)

Testing positive for an STI (Qs 37 & 46) ⁴²

Frequency of STI/HIV testing (Q25)

Frequency of STI/HIV testing * Bareback sex with someone other than CRP (Qs 119 & 138) ⁴³

Relationship status of respondent (Q 89)

Relationship status of respondent * Length of relationship (Q 91)

Term used to describe partner (Q 90)

Relationship status of respondent (recoded)

Opinions about monogamy (Q 88)

Opinions about monogamy * Relationship status of respondent

Opinions about monogamy * Satisfaction with sex life (Qs 93 & 129)

Change opinion about monogamy if lived away/happened in anonymous setting (Q 86)

Opinion of monogamy * Open/closed relationship (Q 96)

Open/closed relationship

Difficulty remaining monogamous (Q 97)

Awareness of partner having sex while monogamous (Q 98)

Had sex with another man/men while monogamous (Q 99)

Kept within limitation of open relationship agreement (Q 109)

Awareness of partner having sex while monogamous * Had sex with another man/men while monogamous

Had sex with another man/men while monogamous * Length of relationship

Consequence for relationship if partner became aware of sex while monogamous (Q 100)

Feeling about partner having sex with other men (Q 106)

Input into open relationship decision (Q 102)

Review of open relationship agreement (Q 103)

Acted upon agreement (Q 107)

Acted upon agreement * Review of open relationship agreement

Nature of relationship agreement (Q 101)

Agreement about use of casual/regular partner (Q 104)

⁴² Due to the complex nature of the survey, some questions were asked over two questions in the survey. This were normally the same question asked within specific branches of the survey (e.g. branches for seropositive and seronegative respondents). In such cases, results from the two individual variables were combined in the dataset to create one new variable.

⁴³ The use of the symbol (*) is used to indicate a crosstabulation table.

Agreement about condom use with other men (Q 105)

Agreement about condom use with other men * Serostatus of respondent

Chapter Six

Bareback sex with someone other than CRP

Bareback sex with someone other than CRP * Serostatus of respondent

Bareback with others (Q 138)

Bareback sex with current partner (Q 114)

Bareback sex with current partner * Length of relationship

Frequency of bareback sex with someone other than CRP (Qs 120 & 141) * Relationship status of respondent

Bareback sex with someone other than CRP * Age of respondent

Bareback sex with someone other than CRP * Sexual role of respondent

Sexual role of respondent * Strategic Positioning (Qs 121 & 143)

Intentionally sought bareback sex with someone other than a CRP (Qs 124 & 142)

Identify as 'bug-chaser' (Qs 126 & 150)

Importance of semen to respondent (Qs 123 & 145)

Importance of semen to respondent * Sexual role of respondent

Perceived risk of acquiring HIV (Q 43) * Sexual role of respondent

Perceived risk of acquiring HIV * Bareback sex with someone other than CRP

Perceived risk of acquiring HIV * Intentionally sought bareback sex with someone other than a CRP

Perceived risk of acquiring HIV * Serosorting

Perceived risk of acquiring HIV * Testing positive for an STI

Perceived risk of acquiring HIV * Testing positive for two STIs at same time (Qs 39 & 48)

Sex with someone known to be seropositive (Q 49)

Sex with someone known to be seropositive * Know people who are seropositive (Q 44)

Chapter Eight

Compulsory to explicitly reveal serostatus on profiles (Q 153)

Compulsory to explicitly reveal serostatus on profiles * Serostatus of respondent

Allude to serostatus (Q 155)

Allude to serostatus * Age of respondent

Allude to serostatus * Serostatus of respondent

Mechanism used to allude to serostatus (Q 156)

Mechanism used to allude to serostatus * Serostatus of respondent

Sought seropositive partner with undetectable viral load (Q 50)

Sought seropositive partner with undetectable viral load * Intentionally sought bareback sex with someone other than a CRP

Withdrawal

Withdrawal * Intentionally sought bareback sex with someone other than a CRP

Strategic Positioning

Strategic Positioning * Sexual role of respondent

Strategic Positioning * Intentionally sought bareback sex with someone other than a CRP

Strategic Positioning * Serostatus of respondent

Serosorting

Serosorting * Intentionally sought bareback sex with someone other than a CRP

Serosorting * Serostatus of respondent

Serosorting * Ever tested for HIV/STI (Q 24)

Serosorting * Frequency of STI/HIV testing

Aware of PrEP trial (Q 53)

Agreement about statements on Prep (Q 54)

Likelihood of men using PrEP after trials (Q 55)

Appendix Seven – SPSS Output

Statistics

What age category do you belong to?

N	Valid	556
	Missing	1
Median		4.0000

What age category do you belong to?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 18-24	138	24.8	24.8	24.8
25-30	118	21.2	21.2	46.0
31-40	132	23.7	23.7	69.8
41-50	118	21.2	21.2	91.0
51+	50	9.0	9.0	100.0
Total	556	99.8	100.0	
Missing System	1	.2		
Total	557	100.0		

Statistics

In which country of the United Kingdom do you live?

N	Valid	553
	Missing	4
Mode		1.00

In which country of the United Kingdom do you live?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid England	463	83.1	83.7	83.7
Scotland	48	8.6	8.7	92.4
Wales	26	4.7	4.7	97.1
Northern Ireland	15	2.7	2.7	99.8
Isle of Man/Channel Islands	1	.2	.2	100.0
Total	553	99.3	100.0	
Missing System	4	.7		
Total	557	100.0		

Statistics

What best describes the area in which you live?

N	Valid	557
	Missing	0
Mode		1.00

What best describes the area in which you live?

	Frequency	Percent	Valid Percent	Cumulative Percent
City	301	54.0	54.0	54.0
Town	191	34.3	34.3	88.3
Valid Village/Countryside	62	11.1	11.1	99.5
Rather not say	3	.5	.5	100.0
Total	557	100.0	100.0	

Statistics

Do you live in any of the following?

N	Valid	551
	Missing	6
Mode		13.00

Do you live in any of the following?

	Frequency	Percent	Valid Percent	Cumulative Percent
Belfast	10	1.8	1.8	1.8
Birmingham	19	3.4	3.4	5.3
Brighton and Hove	14	2.5	2.5	7.8
Valid Bristol	18	3.2	3.3	11.1
Cardiff	8	1.4	1.5	12.5
Edinburgh	14	2.5	2.5	15.1
Glasgow	13	2.3	2.4	17.4
Leeds	14	2.5	2.5	20.0

	Liverpool	8	1.4	1.5	21.4
	London	85	15.3	15.4	36.8
	Manchester	40	7.2	7.3	44.1
	Sheffield	11	2.0	2.0	46.1
	None of the above	226	40.6	41.0	87.1
	Rather not say	6	1.1	1.1	88.2
	Not Applicable	65	11.7	11.8	100.0
	Total	551	98.9	100.0	
Missing	System	6	1.1		
Total		557	100.0		

Statistics

Were you born in the United Kingdom?

N	Valid	557
	Missing	0
Mode		1.00

Were you born in the United Kingdom?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
Yes	502	90.1	90.1	90.1
No	53	9.5	9.5	99.6
Rather not say	2	.4	.4	100.0
Total	557	100.0	100.0	

Statistics

How would you best describe your ethnicity?

N	Valid	554
	Missing	3
Mode		1.00

How would you best describe your ethnicity?

	Frequency	Percent	Valid Percent	Cumulative Percent
--	-----------	---------	---------------	--------------------

Valid	White British	485	87.1	87.5	87.5
	White Irish	15	2.7	2.7	90.3
	Gypsy or Irish Traveller	1	.2	.2	90.4
	White Other	28	5.0	5.1	95.5
	Black Other	2	.4	.4	95.8
	British Asian	3	.5	.5	96.4
	Asian Other	3	.5	.5	96.9
	Latino/South American	2	.4	.4	97.3
	Mixed Ethnic Groups	7	1.3	1.3	98.6
	None of the above	3	.5	.5	99.1
	Rather not say	5	.9	.9	100.0
	Total	554	99.5	100.0	
Missing	System	3	.5		
Total		557	100.0		

Statistics

Are you sexually attracted to:

N	Valid	553
	Missing	4
Mode		1.00

Are you sexually attracted to:

	Frequency	Percent	Valid Percent	Cumulative Percent
Men Only	494	88.7	89.3	89.3
Mostly to men and sometimes to women	48	8.6	8.7	98.0
Valid To men and women equally	4	.7	.7	98.7
Mostly to Women and sometimes to men	7	1.3	1.3	100.0
Total	553	99.3	100.0	
Missing System	4	.7		
Total	557	100.0		

Statistics

Which term best describes your sexuality?

N	Valid	553
	Missing	4
Mode		1.00

Which term best describes your sexuality?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Gay/homosexual	514	92.3	92.9	92.9
Bisexual	17	3.1	3.1	96.0
Queer	7	1.3	1.3	97.3
Straight/heterosexual	1	.2	.2	97.5
Questioning/unsure	2	.4	.4	97.8
I don't use a term to describe my sexuality	8	1.4	1.4	99.3
Other	4	.7	.7	100.0
Total	553	99.3	100.0	
Missing System	4	.7		
Total	557	100.0		

Statistics

How would you describe your sexual role?

N	Valid	553
	Missing	4
Mode		3.00

How would you describe your sexual role?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Top only (I primarily fuck/am sucked)	40	7.2	7.2	7.2
Mainly top, but occasionally bottom	87	15.6	15.7	23.0
Versatile	210	37.7	38.0	60.9
Mainly bottom, but occasionally top	136	24.4	24.6	85.5

Bottom only (I am primarily fucked/suck)	67	12.0	12.1	97.6
Don't know/unsure	13	2.3	2.4	100.0
Total	553	99.3	100.0	
Missing System	4	.7		
Total	557	100.0		

Statistics

How would you describe your drinking habits?

N	Valid	553
	Missing	4
Median		3.0000

How would you describe your drinking habits?

	Frequency	Percent	Valid Percent	Cumulative Percent
Very light drinker	86	15.4	15.6	15.6
Light drinker	125	22.4	22.6	38.2
Moderate drinker	233	41.8	42.1	80.3
Valid Heavy drinker	70	12.6	12.7	92.9
Very heavy drinker	7	1.3	1.3	94.2
Do not drink alcohol	32	5.7	5.8	100.0
Total	553	99.3	100.0	
Missing System	4	.7		
Total	557	100.0		

Statistics

Have you ever used any drugs (including poppers, Viagra or other drugs)?

N	Valid	557
	Missing	0
Mode		1.00

Have you ever used any drugs (including poppers,Viagra or other drugs)?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	400	71.8	71.8	71.8
Valid No	157	28.2	28.2	100.0
Total	557	100.0	100.0	

Case Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
\$DrugUse ^a	398	71.5%	159	28.5%	557	100.0%

a. Dichotomy group tabulated at value 1.

\$DrugUse Frequencies

		Responses		Percent of Cases
		N	Percent	
Combined drug use of respondents ^a	Poppers	352	27.5%	88.4%
	Viagra/Kamagra/Cialis/Levitra	162	12.6%	40.7%
	Marijuana	262	20.5%	65.8%
	Crack Cocaine	51	4.0%	12.8%
	Ketamine	107	8.4%	26.9%
	Ecstasy (MDNA)	177	13.8%	44.5%
	GHB	57	4.4%	14.3%
	Crystal meth	31	2.4%	7.8%
	Other	82	6.4%	20.6%
Total		1281	100.0%	321.9%

a. Dichotomy group tabulated at value 1.

Statistics

Alcohol

N	Valid	553
	Missing	4
Mode		1.00

Alcohol

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	339	60.9	61.3	61.3
	No	57	10.2	10.3	71.6
	Not Applicable	157	28.2	28.4	100.0
	Total	553	99.3	100.0	
Missing	System	4	.7		
Total		557	100.0		

Statistics

One another (e.g. Viagra and
poppers in the one session)

N	Valid	510
	Missing	47
Mode		1.00

One another (e.g. Viagra and poppers in the one session)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	178	32.0	34.9	34.9
	No	172	30.9	33.7	68.6
	Don't know/unsure	3	.5	.6	69.2
	Not Applicable	157	28.2	30.8	100.0
	Total	510	91.6	100.0	
Missing	System	47	8.4		
Total		557	100.0		

Statistics

When I'm high, I make decisions
that I probably wouldn't make if I
wasn't. Do you...?

N	Valid	553
	Missing	4
Median		3.0000

When I'm high, I make decisions that I probably wouldn't make if I wasn't. Do you...?

	Frequency	Percent	Valid Percent	Cumulative Percent
Strongly agree	48	8.6	8.7	8.7
Agree	135	24.2	24.4	33.1
Neutral Opinions	105	18.9	19.0	52.1
Valid Disagree	75	13.5	13.6	65.6
Strongly disagree	33	5.9	6.0	71.6
Not Applicable	157	28.2	28.4	100.0
Total	553	99.3	100.0	
Missing System	4	.7		
Total	557	100.0		

Statistics

Have you ever received an HIV
test result?

N	Valid	557
	Missing	0
Mode		3.00

Have you ever received an HIV test result?

	Frequency	Percent	Valid Percent	Cumulative Percent
No, I have never received an HIV test result	24	4.3	4.3	4.3
Yes, I have tested positive	55	9.9	9.9	14.2
Valid Yes, my last test was negative	390	70.0	70.0	84.2
Not Applicable	88	15.8	15.8	100.0
Total	557	100.0	100.0	

Statistics

Have you ever tested for HIV
and/or other sexually transmitted
infections (STIs)?

N	Valid	557
	Missing	0

Mode	1.00
------	------

Have you ever tested for HIV and/or other sexually transmitted infections (STIs)?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	468	84.0	84.0	84.0
Valid No	88	15.8	15.8	99.8
Valid Rather not say	1	.2	.2	100.0
Total	557	100.0	100.0	

Statistics

I have a HIV and/or STI test

approx

N	Valid	467
	Missing	90
Median		3.0000

I have a HIV and/or STI test approx

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Once every 3 months	56	10.1	12.0	12.0
Valid Once every six months	127	22.8	27.2	39.2
Valid Once a year	130	23.3	27.8	67.0
Valid Less frequently	154	27.6	33.0	100.0
Total	467	83.8	100.0	
Missing System	90	16.2		
Total	557	100.0		

Case Processing Summary

Cases					
Valid		Missing		Total	
N	Percent	N	Percent	N	Percent

I have a HIV and/or STI test approx * Have you ever had bb sex with someone other than a relationship partner?	463	83.1%	94	16.9%	557	100.0%
----------------------------------------------------------------------------------------------------------------	-----	-------	----	-------	-----	--------

I have a HIV and/or STI test approx * Have you ever had bb sex with someone other than a relationship partner? Crosstabulation

			Have you ever had bb sex with someone other than a relationship partner?		Total
			Yes	No	
I have a HIV and/or STI test approx	Count		53	3	56
	Once every 3 months	% within I have a HIV and/or STI test approx	94.6%	5.4%	100.0%
	Count		99	27	126
	Once every six months	% within I have a HIV and/or STI test approx	78.6%	21.4%	100.0%
	Count		101	27	128
	Once a year	% within I have a HIV and/or STI test approx	78.9%	21.1%	100.0%
	Count		109	44	153
	Less frequently	% within I have a HIV and/or STI test approx	71.2%	28.8%	100.0%
Total	Count		362	101	463
	% within I have a HIV and/or STI test approx		78.2%	21.8%	100.0%

Statistics

How would you describe your current relationship status?

N	Valid	557
	Missing	0
Mode		1.00

How would you describe your current relationship status?

	Frequency	Percent	Valid Percent	Cumulative Percent
Civil Partnership or committed relationship	240	43.1	43.1	43.1
Married to a man	14	2.5	2.5	45.6
Married to a woman	6	1.1	1.1	46.7
Valid Currently dating	81	14.5	14.5	61.2
Single	209	37.5	37.5	98.7
Rather not say	7	1.3	1.3	100.0
Total	557	100.0	100.0	

Statistics

How would you describe your current relationship status?

N	Valid	557
	Missing	0
Mode		1.00

How would you describe your current relationship status?

	Frequency	Percent	Valid Percent	Cumulative Percent
Civil Partnership or committed relationship	240	43.1	43.1	43.1
Married to a man	14	2.5	2.5	45.6
Married to a woman	6	1.1	1.1	46.7
Valid Currently dating	81	14.5	14.5	61.2
Single	209	37.5	37.5	98.7
Rather not say	7	1.3	1.3	100.0
Total	557	100.0	100.0	

Case Processing Summary

	Cases
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	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
How long have you been with your [Q90]? * How would you describe your current relationship status?	331	59.4%	226	40.6%	557	100.0%

How long have you been with your [Q90]? * How would you describe your current relationship status? Crosstabulation

			How would you describe your current relationship status?			Total
			Civil Partnership or committed relationship	Married to a man	Currently dating	
How long have you been with your [Q90]?		Count	5	0	28	33
	Less than six months	% within How would you describe your current relationship status?	2.1%	0.0%	34.6%	10.0%
		Count	21	1	19	41
	6 months - 1 year	% within How would you describe your current relationship status?	8.9%	7.1%	23.5%	12.4%
		Count	42	0	16	58
	1 - 2 years	% within How would you describe your current relationship status?	17.8%	0.0%	19.8%	17.5%
		Count	34	5	12	51
	3 - 4 years	% within How would you describe your current relationship status?	14.4%	35.7%	14.8%	15.4%
		Count	134	8	6	148
	Five or more years	% within How would you describe your current relationship status?	56.8%	57.1%	7.4%	44.7%
Total		Count	236	14	81	331

% within How would you describe your current relationship status?	100.0%	100.0%	100.0%	100.0%
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Statistics

Which term would you use?

N	Valid	335
	Missing	222
Mode		3.00

Which term would you use?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Boyfriend	139	25.0	41.5	41.5
	Husband	39	7.0	11.6	53.1
	Partner	157	28.2	46.9	100.0
	Total	335	60.1	100.0	
Missing	System	222	39.9		
Total		557	100.0		

Statistics

Are you single or in a relationship?

N	Valid	550
	Missing	7
Mode		1.00

Are you single or in a relationship?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	In relationship	335	60.1	60.9	60.9
	Single	215	38.6	39.1	100.0
	Total	550	98.7	100.0	
Missing	System	7	1.3		
Total		557	100.0		

Statistics

Overall, for me, monogamy is...

N	Valid	513
	Missing	44
Mode		1.00

Overall, for me, monogamy is...

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Something I am wholly committed to	226	40.6	44.1	44.1
	An ideal to which I aspire	176	31.6	34.3	78.4
	An uncomfortable pretence	46	8.3	9.0	87.3
	An unnecessary constraint	65	11.7	12.7	100.0
	Total	513	92.1	100.0	
Missing	System	44	7.9		
Total		557	100.0		

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Overall, for me, monogamy is... * Are you single or in a relationship?	507	91.0%	50	9.0%	557	100.0%

Overall, for me, monogamy is... * Are you single or in a relationship? Crosstabulation

			Are you single or in a relationship?		Total
			In relationship	Single	
Overall, for me, monogamy is...	Something I am wholly committed to	Count	158	67	225
		% within Are you single or in a relationship?	51.6%	33.3%	44.4%
		Count	80	94	174

	An ideal to which I aspire	% within Are you single or in a relationship?	26.1%	46.8%	34.3%
		Count	25	19	44
	An uncomfortable pretence	% within Are you single or in a relationship?	8.2%	9.5%	8.7%
		Count	43	21	64
	An unnecessary constraint	% within Are you single or in a relationship?	14.1%	10.4%	12.6%
		Count	306	201	507
Total		% within Are you single or in a relationship?	100.0%	100.0%	100.0%

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Overall, for me, monogamy is... * Overall, are you satisfied with your sex life?	502	90.1%	55	9.9%	557	100.0%

Overall, for me, monogamy is... * Overall, are you satisfied with your sex life? Crosstabulation

			Overall, are you satisfied with your sex life?			Total
			Satisfied	Neither	Dissatisfied	
Overall, for me, monogamy is...		Count	141	32	50	223
	Something I am wholly committed to	% within Overall, are you satisfied with your sex life?	55.1%	38.6%	30.7%	44.4%
		Count	66	32	75	173
	An ideal to which I aspire	% within Overall, are you satisfied with your sex life?	25.8%	38.6%	46.0%	34.5%
		Count	13	8	22	43
	An uncomfortable pretence	% within Overall, are you satisfied with your sex life?	5.1%	9.6%	13.5%	8.6%
		Count	36	11	16	63
	An unnecessary constraint	% within Overall, are you satisfied with your sex life?	14.1%	13.3%	9.8%	12.5%

Total	Count	256	83	163	502
	% within Overall, are you satisfied with your sex life?	100.0%	100.0%	100.0%	100.0%

Statistics

He/you spent time away from
home and/or lived abroad

N	Valid	543
	Missing	14
Mode		2.00

He/you spent time away from home and/or lived abroad

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	106	19.0	19.5	19.5
	No	382	68.6	70.3	89.9
	Don't know/unsure	55	9.9	10.1	100.0
	Total	543	97.5	100.0	
Missing	System	14	2.5		
Total		557	100.0		

Statistics

He/you spent time away from
home and/or lived abroad

N	Valid	543
	Missing	14
Mode		2.00

He/you spent time away from home and/or lived abroad

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	106	19.0	19.5	19.5
	No	382	68.6	70.3	89.9
	Don't know/unsure	55	9.9	10.1	100.0

Total	543	97.5	100.0
Missing System	14	2.5	
Total	557	100.0	

Statistics

Sex happened in an anonymous setting (e.g. darkroom, gloryhole)

N	Valid	543
	Missing	14
Mode		2.00

Sex happened in an anonymous setting (e.g. darkroom, gloryhole)

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	61	11.0	11.2	11.2
Valid No	457	82.0	84.2	95.4
Valid Don't know/unsure	25	4.5	4.6	100.0
Total	543	97.5	100.0	
Missing System	14	2.5		
Total	557	100.0		

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Overall, for me, monogamy is... * Have you and your [Q90] made an agreement that would allow either, or both, of you to have sex with other men?	302	54.2%	255	45.8%	557	100.0%

Overall, for me, monogamy is... * Have you and your [Q90] made an agreement that would allow either, or both, of you to have sex with other men? Crosstabulation

			Have you and your [Q90] made an agreement that would allow either, or both, of you to have sex with other men?		Total
			Yes	No	
Overall, for me, monogamy is...	Something I am wholly committed to	Count	13	143	156
		% within Have you and your [Q90] made an agreement that would allow either, or both, of you to have sex with other men?	15.3%	65.9%	51.7%
	An ideal to which I aspire	Count	17	62	79
		% within Have you and your [Q90] made an agreement that would allow either, or both, of you to have sex with other men?	20.0%	28.6%	26.2%
	An uncomfortable pretense	Count	17	7	24
		% within Have you and your [Q90] made an agreement that would allow either, or both, of you to have sex with other men?	20.0%	3.2%	7.9%
	An unnecessary constraint	Count	38	5	43
		% within Have you and your [Q90] made an agreement that would allow either, or both, of you to have sex with other men?	44.7%	2.3%	14.2%
	Total	Count	85	217	302
		% within Have you and your [Q90] made an agreement that would allow either, or both, of you to have sex with other men?	100.0%	100.0%	100.0%

Have you and your [Q90] made an agreement that would allow either, or both, of you to have sex with other men?

N	Valid	330
	Missing	227
Mode		2.00

Have you and your [Q90] made an agreement that would allow either, or both, of you to have sex with other men?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	103	18.5	31.2	31.2
	No	227	40.8	68.8	100.0
	Total	330	59.2	100.0	
Missing	System	227	40.8		
Total		557	100.0		

Statistics

Do you find it difficult to remain monogamous to your partner?

N	Valid	226
	Missing	331
Mode		1.00

Do you find it difficult to remain monogamous to your partner?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	113	20.3	50.0	50.0
	Sometimes	95	17.1	42.0	92.0
	Often	18	3.2	8.0	100.0
	Total	226	40.6	100.0	
Missing	System	331	59.4		
Total		557	100.0		

Statistics

As far as you are aware, has your
[Q90] ever had sex with another
man/men during periods of
monogamy within your
relationship?

N	Valid	225
	Missing	332
Mode		2.00

**As far as you are aware, has your [Q90] ever had sex with another man/men during
periods of monogamy within your relationship?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	24	4.3	10.7	10.7
Valid No	171	30.7	76.0	86.7
Valid Don't know/Unsure	30	5.4	13.3	100.0
Valid Total	225	40.4	100.0	
Missing System	332	59.6		
Total	557	100.0		

Statistics

Have you ever had any form of
sex with another man/men while
you were supposed to be
monogamous to your [Q90]?

N	Valid	222
	Missing	335
Mode		2.00

**Have you ever had any form of sex with another man/men while you were
supposed to be monogamous to your [Q90]?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	67	12.0	30.2	30.2
Valid No	155	27.8	69.8	100.0
Valid Total	222	39.9	100.0	
Missing System	335	60.1		

Total	557	100.0		
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Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
As far as you are aware, has your [Q90] ever had sex with another man/men during periods of monogamy within your relationship? * Have you ever had any form of sex with another man/men while you were supposed to be monogamous to your [Q90]?	220	39.5%	337	60.5%	557	100.0%

As far as you are aware, has your [Q90] ever had sex with another man/men during periods of monogamy within your relationship? * Have you ever had any form of sex with another man/men while you were supposed to be monogamous to your [Q90]? Crosstabulation

			Have you ever had any form of sex with another man/men while you were supposed to be monogamous to your [Q90]?		Total
			Yes	No	
As far as you are aware, has your [Q90] ever had sex with another man/men during periods of monogamy within your relationship?	Yes	Count	11	12	23
		% within As far as you are aware, has your [Q90] ever had sex with another man/men during periods of monogamy within your relationship?	47.8%	52.2%	100.0%
No			40	129	169

Total	Don't know/Unsure	% within As far as you are aware, has your [Q90] ever had sex with another man/men during periods of monogamy within your relationship?	23.7%	76.3%	100.0%
		Count	15	13	28
		% within As far as you are aware, has your [Q90] ever had sex with another man/men during periods of monogamy within your relationship?	53.6%	46.4%	100.0%
		Count	66	154	220
		% within As far as you are aware, has your [Q90] ever had sex with another man/men during periods of monogamy within your relationship?	30.0%	70.0%	100.0%
		Count			

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever had any form of sex with another man/men while you were supposed to be monogamous to your [Q90]? * How long have you been with your [Q90]?	220	39.5%	337	60.5%	557	100.0%

Have you ever had any form of sex with another man/men while you were supposed to be monogamous to your [Q90]? * How long have you been with your [Q90]? Crosstabulation

	How long have you been with your [Q90]?					Total
	Less than six months	6 months - 1 year	1 - 2 years	3 - 4 years	Five or more years	
Yes Count	6	4	13	9	34	66

Have you ever had any form of sex with another man/men while you were supposed to be monogamous to your [Q90]?		% within Have you ever had any form of sex with another man/men while you were supposed to be monogamous to your [Q90]?	9.1%	6.1%	19.7%	13.6%	51.5%	100.0%
		Count	23	28	32	34	37	154
		% within Have you ever had any form of sex with another man/men while you were supposed to be monogamous to your [Q90]?	14.9%	18.2%	20.8%	22.1%	24.0%	100.0%
		Count	29	32	45	43	71	220
Total	No	% within Have you ever had any form of sex with another man/men while you were supposed to be monogamous to your [Q90]?	13.2%	14.5%	20.5%	19.5%	32.3%	100.0%
		Count	29	32	45	43	71	220
		% within Have you ever had any form of sex with another man/men while you were supposed to be monogamous to your [Q90]?	13.2%	14.5%	20.5%	19.5%	32.3%	100.0%
		Count	29	32	45	43	71	220

Statistics

If your [Q90] was aware that you had sex with another man, what do you think would be the consequences for your relationship?

N	Valid	68
	Missing	489

If your [Q90] was aware that you had sex with another man, what do you think would be the consequences for your relationship?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid He would end it immediately	11	2.0	16.2	16.2

I think it would make him insecure and lead to the beginning	34	6.1	50.0	66.2
I think he would be upset, but would understand	11	2.0	16.2	82.4
I don't think it would bother him very much	2	.4	2.9	85.3
I told him about the sex I had	7	1.3	10.3	95.6
Other (please specify)	3	.5	4.4	100.0
Total	68	12.2	100.0	
Missing System	489	87.8		
Total	557	100.0		

Statistics

How do you feel about your [Q90]
having sex with other men?

N	Valid	100
	Missing	457
Mode		2.00

How do you feel about your [Q90] having sex with other men?

	Frequency	Percent	Valid Percent	Cumulative Percent
He doesn't have sex with others	8	1.4	8.0	8.0
It doesn't bother me or affect our relationship	59	10.6	59.0	67.0
Valid It bothers me a little, but its no big deal	25	4.5	25.0	92.0
It bothers me a lot, but I enjoy sex with other men so can't	8	1.4	8.0	100.0
Total	100	18.0	100.0	
Missing System	457	82.0		
Total	557	100.0		

Statistics

Do you think that yourself and
your [Q90] had equal input into
your decision to open your
relationship?

N	Valid	102
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Missing	455
Mode	1.00

Do you think that yourself and your [Q90] had equal input into your decision to open your relationship?

	Frequency	Percent	Valid Percent	Cumulative Percent
I think we both had input and made the decisions equally	73	13.1	71.6	71.6
I think I made more of the decisions than him	15	2.7	14.7	86.3
I think he made more of the decisions than me	14	2.5	13.7	100.0
Total	102	18.3	100.0	
Missing System	455	81.7		
Total	557	100.0		

Statistics

Have you ever reviewed the original agreement with your [Q90]?

N	Valid	100
	Missing	457
Mode		4.00

Have you ever reviewed the original agreement with your [Q90]?

	Frequency	Percent	Valid Percent	Cumulative Percent
It is only a recent agreement and we haven't gone back to it	16	2.9	16.0	16.0
It was made on one occasion only and we haven't spoken about	25	4.5	25.0	41.0
We have reviewed the agreement once	10	1.8	10.0	51.0

	We have reviewed the agreement a number of times	49	8.8	49.0	100.0
	Total	100	18.0	100.0	
Missing	System	457	82.0		
Total		557	100.0		

Statistics

Have you acted upon your agreement and had sex outside your relationship?

N	Valid	103
	Missing	454
Mode		1.00

Have you acted upon your agreement and had sex outside your relationship?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	85	15.3	82.5	82.5
Valid No	18	3.2	17.5	100.0
Total	103	18.5	100.0	
Missing System	454	81.5		
Total	557	100.0		

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever reviewed the original agreement with your [Q90]? * Have you acted upon your agreement and had sex outside your relationship?	100	18.0%	457	82.0%	557	100.0%

Have you ever reviewed the original agreement with your [Q90]? * Have you acted upon your agreement and had sex outside your relationship? Crosstabulation

			Have you acted upon your agreement and had sex outside your relationship?		Total
			Yes	No	
Have you ever reviewed the original agreement with your [Q90]?	Count		12	4	16
	It is only a recent agreement and we haven't gone back to it	% within Have you acted upon your agreement and had sex outside your relationship?	14.3%	25.0%	16.0%
	Count		22	3	25
	It was made on one occasion only and we haven't spoken about	% within Have you acted upon your agreement and had sex outside your relationship?	26.2%	18.8%	25.0%
	Count		9	1	10
	We have reviewed the agreement once	% within Have you acted upon your agreement and had sex outside your relationship?	10.7%	6.3%	10.0%
Total	Count		41	8	49
	We have reviewed the agreement a number of times	% within Have you acted upon your agreement and had sex outside your relationship?	48.8%	50.0%	49.0%
	Count		84	16	100
		% within Have you acted upon your agreement and had sex outside your relationship?	100.0%	100.0%	100.0%

Case Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
\$RelAgree ^a	97	17.4%	460	82.6%	557	100.0%

a. Dichotomy group tabulated at value 1.

\$RelArr Frequencies

		Responses		Percent of Cases
		N	Percent	
Part of relationship agreement ^a	Don't have sex in our home/s	21	11.4%	21.6%
	Never have sex with the same person twice	9	4.9%	9.3%
	Never have sex with an ex	22	11.9%	22.7%
	Never sleep with friends	22	11.9%	22.7%
	Don't have group sex	2	1.1%	2.1%
	Don't sleep over	31	16.8%	32.0%
	Don't share details for contact afterwards	17	9.2%	17.5%
	Only have oral sex with others	2	1.1%	2.1%
	Only have threesomes in the company of your partners	28	15.1%	28.9%
	Only fuck, never be fucked	4	2.2%	4.1%
	Don't do some act (e.g. kiss) with others	6	3.2%	6.2%
	None of the above	21	11.4%	21.6%
Total		185	100.0%	190.7%

a. Dichotomy group tabulated at value 1.

Statistics

What type of agreement was made about using regular (i.e men you'd meet three or more times) or casual partners (men you'd met once or twice)?

N	Valid	102
	Missing	455
Mode		4.00

What type of agreement was made about using regular (i.e men you'd meet three or more times) or casual partners (men you'd met once or twice)?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	We agreed to use regular partners only	8	1.4	7.8	7.8

	We agreed to use casual partners only	15	2.7	14.7	22.5
	We agreed to use casual and regular partners	24	4.3	23.5	46.1
	We have not made any agreement about regular/casual partners	55	9.9	53.9	100.0
	Total	102	18.3	100.0	
Missing	System	455	81.7		
Total		557	100.0		

Statistics

Do you have an agreement with your [Q90] about using condoms while having anal sex with other men?

N	Valid	99
	Missing	458
Mode		1.00

Do you have an agreement with your [Q90] about using condoms while having anal sex with other men?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
	Yes, condoms are to be used at all times.	58	10.4	58.6
	Yes, but it is left up to our discretion as to whether one is needed	13	2.3	71.7
	No, we don't have any agreement about using condoms.	25	4.5	97.0
	No, we don't have anal sex with other guys.	3	.5	100.0
	Total	99	17.8	100.0
Missing	System	458	82.2	
Total		557	100.0	

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Do you have an agreement with your [Q90] about using condoms while having anal sex with other men? * Have you ever received a HIV test result?	96	17.2%	461	82.8%	557	100.0%

Do you have an agreement with your [Q90] about using condoms while having anal sex with other men? * Have you ever received a HIV test result? Crosstabulation

			Have you ever received a HIV test result?			Total
			No, I have never received a HIV test result	Yes, I have tested positive	Yes, my last test was negative	
Do you have an agreement with your [Q90] about using condoms while having anal sex with other men?	Yes, condoms are to be used at all times.	Count	1	5	50	56
		% within Have you ever received a HIV test result?	33.3%	31.3%	64.9%	58.3%
	Yes, but it is left up to our discretion as to whether one is needed	Count	1	3	9	13
		% within Have you ever received a HIV test result?	33.3%	18.8%	11.7%	13.5%
	No, we don't have any agreement about using condoms.	Count	1	8	15	24
		% within Have you ever received a HIV test result?	33.3%	50.0%	19.5%	25.0%
	Count	0	0	3	3	

Total	No, we don't have anal sex with other guys.	% within	0.0%	0.0%	3.9%	3.1%
		Have you ever received a HIV test result?				
		Count	3	16	77	96
		% within	100.0%	100.0%	100.0%	100.0%
		Have you ever received a HIV test result?				

Statistics

Have you ever had bareback sex
with someone other than current
partner (if you have one)?

N	Valid	556
	Missing	1

Have you ever had bareback sex with someone other than current partner (if you
have one)?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	407	73.1	73.2	73.2
	No	145	26.0	26.1	99.3
	Rather not say	4	.7	.7	100.0
	Total	556	99.8	100.0	
Missing	System	1	.2		
Total		557	100.0		

Case Processing Summary

						Cases					
						Valid		Missing		Total	
						N	Percent	N	Percent	N	Percent

Have you ever had bareback sex with someone other than a relationship partner? * Have you ever received a HIV test result?	468	84.0%	89	16.0%	557	100.0%
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Have you ever had bareback sex with someone other than a relationship partner? * Have you ever received a HIV test result? Crosstabulation

			Have you ever received a HIV test result?			Total
			No, I have never received a HIV test result	Yes, I have tested positive	Yes, my last test was negative	
Have you ever had bareback sex with someone other than a relationship partner?	Yes	Count	15	52	297	364
		% within Have you ever received a HIV test result?	62.5%	94.5%	76.3%	77.8%
	No	Count	9	2	90	101
		% within Have you ever received a HIV test result?	37.5%	3.6%	23.1%	21.6%
	Rather not say	Count	0	1	2	3
		% within Have you ever received a HIV test result?	0.0%	1.8%	0.5%	0.6%
	Total	Count	24	55	389	468
		% within Have you ever received a HIV test result?	100.0%	100.0%	100.0%	100.0%

Statistics

Have you ever had bb sex?

N	Valid	221
	Missing	336

Have you ever had bb sex?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	174	31.2	78.7	78.7
	No	45	8.1	20.4	99.1
	Rather not say	2	.4	.9	100.0
	Total	221	39.7	100.0	
Missing	System	336	60.3		
Total		557	100.0		

Statistics

Have you ever had bb sex with
your current partner?

N	Valid	332
	Missing	225

Have you ever had bb sex with your current partner?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	274	49.2	82.5	82.5
	No	58	10.4	17.5	100.0
	Total	332	59.6	100.0	
Missing	System	225	40.4		
Total		557	100.0		

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever had bb sex with your current partner? *	328	58.9%	229	41.1%	557	100.0%
How long have you been with your [Q90]?						

Have you ever had bb sex with your current partner? * How long have you been with your [Q90]?

Crosstabulation

		How long have you been with your [Q90]?					Total
		Less than six months	6 months - 1 year	1 - 2 years	3 - 4 years	Five or more years	
Have you ever had bb sex with your current partner?	Count	18	33	55	40	124	270
	% within How long have you been with your [Q90]?	54.5%	80.5%	94.8%	80.0%	84.9%	82.3%
	Yes						
	Count	15	8	3	10	22	58
	% within How long have you been with your [Q90]?	45.5%	19.5%	5.2%	20.0%	15.1%	17.7%
	No						
	Count	33	41	58	50	146	328
	% within How long have you been with your [Q90]?	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Total							

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Excluding men with whom you have had a relationship, how often would you say you have barebacked? * How would you describe your current relationship status?	402	72.2%	155	27.8%	557	100.0%

Excluding men with whom you have had a relationship, how often would you say you have barebacked? * How would you describe your current relationship status? Crosstabulation

		How would you describe your current relationship status?		Total
		In a relationship	Single	
Never	Count	44	21	65

Excluding men with whom you have had a relationship, how often would you say you have barebacked?		% within How would you describe your current relationship status?	19.0%	12.4%	16.2%
		Count	90	61	151
	Rarely	% within How would you describe your current relationship status?	38.8%	35.9%	37.6%
		Count	42	48	90
	Sometimes	% within How would you describe your current relationship status?	18.1%	28.2%	22.4%
		Count	27	27	54
	Often	% within How would you describe your current relationship status?	11.6%	15.9%	13.4%
		Count	28	12	40
	Very often	% within How would you describe your current relationship status?	12.1%	7.1%	10.0%
		Count	1	1	2
	Non response	% within How would you describe your current relationship status?	0.4%	0.6%	0.5%
		Count	232	170	402
	Total	% within How would you describe your current relationship status?	100.0%	100.0%	100.0%

Case Processing Summary

Cases					
Valid		Missing		Total	
N	Percent	N	Percent	N	Percent

Have you ever had bb sex with someone other than a relationship partner? * What age category do you belong to?	552	99.1%	5	0.9%	557	100.0%
----------------------------------------------------------------------------------------------------------------	-----	-------	---	------	-----	--------

Have you ever had bb sex with someone other than a relationship partner? * What age category do you belong to? Crosstabulation

		What age category do you belong to?					Total
		18-24	25-30	31-40	41-50	51+	
Have you ever had bb sex with someone other than a relationship partner?	Count	87	90	102	91	37	407
	Yes % within What age category do you belong to?	63.0%	77.6%	77.9%	77.1%	75.5%	73.7%
	Count	51	26	29	27	12	145
	No % within What age category do you belong to?	37.0%	22.4%	22.1%	22.9%	24.5%	26.3%
	Count	138	116	131	118	49	552
	Total % within What age category do you belong to?	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever had bareback sex with someone other than a relationship partner? * How would you describe your sexual role?	539	96.8%	18	3.2%	557	100.0%

Have you ever had bareback sex with someone other than a relationship partner? * How would you describe your sexual role? Crosstabulation

		How would you describe your sexual role?					Total
		Top only	Mainly top, but occasionally bottom	Versatile	Mainly bottom, but occasionally top	Bottom only	
Yes	Count	31	66	153	105	46	401

Have you ever had bareback sex with someone other than a relationship partner?	No	% within	77.5%	75.9%	73.2%	77.2%	68.7%	74.4%
		How would you describe your sexual role?						
		Count	9	21	55	30	21	136
	Rather not say	% within	22.5%	24.1%	26.3%	22.1%	31.3%	25.2%
		How would you describe your sexual role?						
		Count	0	0	1	1	0	2
Total		% within	0.0%	0.0%	0.5%	0.7%	0.0%	0.4%
		How would you describe your sexual role?						
		Count	40	87	209	136	67	539
		% within	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
How would you describe your sexual role? * Are you more likely to take an active/top role when barebacking with others?	226	40.6%	331	59.4%	557	100.0%

How would you describe your sexual role? * Are you more likely to take an active/top role when barebacking with others? Crosstabulation

			Are you more likely to take an active/top role when barebacking with others?			Total
			Yes, I am more likely to take an active role	No, I do not change my role	I am an active partner whether barebacking or not	
How would you describe your sexual role?	Top only	Count	6	3	5	14
		% within How would you describe your sexual role?	42.9%	21.4%	35.7%	100.0%
	Mainly top, but occasionally bottom	Count	17	12	11	40
		% within How would you describe your sexual role?	42.5%	30.0%	27.5%	100.0%
	Versatile	Count	20	54	15	89
		% within How would you describe your sexual role?	22.5%	60.7%	16.9%	100.0%
	Mainly bottom, but occasionally top	Count	11	44	1	56
		% within How would you describe your sexual role?	19.6%	78.6%	1.8%	100.0%
	Bottom only	Count	2	25	0	27
		% within How would you describe your sexual role?	7.4%	92.6%	0.0%	100.0%
Total	Count	56	138	32	226	
	% within How would you describe your sexual role?	24.8%	61.1%	14.2%	100.0%	

Statistics

Have you ever intentionally
sought bb sex for someone you
have had sex with?

N	Valid	406
	Missing	151

Have you ever intentionally sought bb sex for someone you have had sex with?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	144	25.9	35.5	35.5
No	233	41.8	57.4	92.9
Valid Don't know/unsure	19	3.4	4.7	97.5
Non response	10	1.8	2.5	100.0
Total	406	72.9	100.0	
Missing System	151	27.1		
Total	557	100.0		

Statistics

Would you ever use the term 'bug
chaser' to describe yourself?

N	Valid	406
	Missing	151

Would you ever use the term 'bug chaser' to describe yourself?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	12	2.2	3.0	3.0
No	386	69.3	95.1	98.0
Valid Unsure	7	1.3	1.7	99.8
Non response	1	.2	.2	100.0
Total	406	72.9	100.0	
Missing System	151	27.1		
Total	557	100.0		

Statistics

To receive cum during anal sex

N	Valid	373
	Missing	184
Median		2.0000

To receive cum during anal sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Important	154	27.6	41.3	41.3
	Neither	94	16.9	25.2	66.5
	Unimportant	125	22.4	33.5	100.0
	Total	373	67.0	100.0	
Missing	System	184	33.0		
Total		557	100.0		

Statistics

To give cum during anal sex

N	Valid	379
	Missing	178
Median		2.0000

To give cum during anal sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Important	140	25.1	36.9	36.9
	Neither	113	20.3	29.8	66.8
	Unimportant	126	22.6	33.2	100.0
	Total	379	68.0	100.0	
Missing	System	178	32.0		
Total		557	100.0		

Case Processing Summary

						Cases					
						Valid		Missing		Total	
						N	Percent	N	Percent	N	Percent

How important is it for you to give cum during anal sex? *	375	67.3%	182	32.7%	557	100.0%
How would you describe your sexual role?						
How important is it for you to receive cum during anal sex?	370	66.4%	187	33.6%	557	100.0%
* How would you describe your sexual role?						

Crosstab

		How would you describe your sexual role?					Total	
		Top only	Mainly top, but occasionally bottom	Versatile	Mainly bottom, but occasionally top	Bottom only		
How important is it for you to give cum during anal sex?	Important	Count	16	24	62	29	7	138
		% within	55.2%	36.9%	42.5%	29.9%	18.4%	36.8%
		How would you describe your sexual role?						
	Neither	Count	6	16	44	32	15	113
		% within	20.7%	24.6%	30.1%	33.0%	39.5%	30.1%
		How would you describe your sexual role?						
How important is it for you to receive cum during anal sex?	Unimportant	Count	7	25	40	36	16	124
		% within	24.1%	38.5%	27.4%	37.1%	42.1%	33.1%
		How would you describe your sexual role?						
	Neither	Count	7	25	40	36	16	124
		% within	24.1%	38.5%	27.4%	37.1%	42.1%	33.1%
		How would you describe your sexual role?						
Total		Count	29	65	146	97	38	375

	% within	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	How						
	would						
	you						
	describe						
	your						
	sexual						
	role?						

Crosstab

		How would you describe your sexual role?					Total	
		Top only	Mainly top, but occasionally bottom	Versatile	Mainly bottom, but occasionally top	Bottom only		
How important is it for you to receive cum during anal sex?	Important	Count	6	17	64	41	25	153
		% within	27.3%	28.3%	43.5%	42.3%	56.8%	41.4%
		How would you describe your sexual role?						
	Neither	Count	4	11	43	27	10	95
		% within	18.2%	18.3%	29.3%	27.8%	22.7%	25.7%
		How would you describe your sexual role?						
Unimportant	Count	12	32	40	29	9	122	

Total	% within	54.5%	53.3%	27.2%	29.9%	20.5%	33.0%
	How						
	would						
	you						
	describe						
	your						
Total	sexual						
	role?						
	Count	22	60	147	97	44	370
	% within	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	How						
	would						
Total	you						
	describe						
	your						
	sexual						
	role?						

Statistics

Given my sex life, I believe I am
at risk of getting HIV. Do you...??

N	Valid	501
	Missing	56
Median		3.0000

Given my sex life, I believe I am at risk of getting HIV. Do you...??

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	107	19.2	21.4	21.4
	Neither/unsure	65	11.7	13.0	34.3
	Disagree	329	59.1	65.7	100.0
	Total	501	89.9	100.0	
Missing	System	56	10.1		
Total		557	100.0		

Case Processing Summary

						Cases					
						Valid		Missing		Total	
						N	Percent	N	Percent	N	Percent

Have you ever had bb sex with someone other than a relationship partner? * Given my sex life, I believe I am at risk of getting HIV. Do you...??	497	89.2%	60	10.8%	557	100.0%
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Have you ever had bb sex with someone other than a relationship partner? * Given my sex life, I believe I am at risk of getting HIV. Do you...?? Crosstabulation

		Given my sex life, I believe I am at risk of getting HIV. Do you...??			Total
		Agree	Neither/unsure	Disagree	
Have you ever had bb sex with someone other than a relationship partner?	Count	88	49	217	354
	% within Have you ever	24.9%	13.8%	61.3%	100.0%
	Yes				
	had bb sex with				
	someone other than a				
	relationship partner?				
Total	Count	18	14	111	143
	% within Have you ever	12.6%	9.8%	77.6%	100.0%
	No				
	had bb sex with				
	someone other than a				
	relationship partner?				
Total	Count	106	63	328	497
	% within Have you ever	21.3%	12.7%	66.0%	100.0%
	had bb sex with				
	someone other than a				
	relationship partner?				

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever intentionally sought bb sex for someone you have had sex with? * Given my sex life, I believe I am at risk of getting HIV. Do you...??	326	58.5%	231	41.5%	557	100.0%

Have you ever intentionally sought bb sex for someone you have had sex with? * Given my sex life, I believe I am at risk of getting HIV. Do you...?? Crosstabulation

	Given my sex life, I believe I am at risk of getting HIV. Do you...??	Total
--	-----------------------------------------------------------------------	-------

		Agree	Neither/unsure	Disagree	
Have you ever intentionally sought bb sex for someone you have had sex with?	Count	48	17	44	109
	% within Have you ever	44.0%	15.6%	40.4%	100.0%
	Yes intentionally sought bb sex for someone you have had sex with?				
	Count	35	26	156	217
	% within Have you ever	16.1%	12.0%	71.9%	100.0%
	No intentionally sought bb sex for someone you have had sex with?				
Total	Count	83	43	200	326
	% within Have you ever	25.5%	13.2%	61.3%	100.0%
	intentionally sought bb sex for someone you have had sex with?				

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever made an agreement with a sex partner of the same HIV status to bb with one another? * Given my sex life, I believe I am at risk of getting HIV. Do you...??	350	62.8%	207	37.2%	557	100.0%

Have you ever made an agreement with a sex partner of the same HIV status to bb with one another? * Given my sex life, I believe I am at risk of getting HIV. Do you...?? Crosstabulation

		Given my sex life, I believe I am at risk of getting HIV. Do you...??			Total
		Agree	Neither/unsure	Disagree	
Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	Count	56	20	88	164
	% within Have you ever	34.1%	12.2%	53.7%	100.0%
	Yes made an agreement with a sex partner of the same HIV status to bb with one another?				
No	Count	31	29	126	186

Total	% within Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	16.7%	15.6%	67.7%	100.0%
	Count	87	49	214	350
	% within Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	24.9%	14.0%	61.1%	100.0%
	Count				

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever tested positive for a sexually transmitted infected? * Given my sex life, I believe I am at risk of getting HIV. Do you...??	495	88.9%	62	11.1%	557	100.0%

Have you ever tested positive for a sexually transmitted infected? * Given my sex life, I believe I am at risk of getting HIV. Do you...?? Crosstabulation

		Given my sex life, I believe I am at risk of getting HIV. Do you...??			Total
		Agree	Neither/unsure	Disagree	
Have you ever tested positive for a sexually transmitted infected?	Count	61	25	110	196
	% within Have you ever tested positive for a sexually transmitted infected?	31.1%	12.8%	56.1%	100.0%
	Count	45	38	216	299
	% within Have you ever tested positive for a sexually transmitted infected?	15.1%	12.7%	72.2%	100.0%
Total	Count	106	63	326	495

% within Have you ever tested positive for a sexually transmitted infected?	21.4%	12.7%	65.9%	100.0%
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Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever had more than one infection at the same time? * Given my sex life, I believe I am at risk of getting HIV. Do you...??	186	33.4%	371	66.6%	557	100.0%

Have you ever had more than one infection at the same time? * Given my sex life, I believe I am at risk of getting HIV. Do you...?? Crosstabulation

		Given my sex life, I believe I am at risk of getting HIV. Do you...??			Total
		Agree	Neither/unsure	Disagree	
Have you ever had more than one infection at the same time?	Count	15	2	10	27
	% within Have you ever had more than one infection at the same time?	55.6%	7.4%	37.0%	100.0%
	Yes				
	Count	44	21	94	159
	% within Have you ever had more than one infection at the same time?	27.7%	13.2%	59.1%	100.0%
	No				
Total	Count	59	23	104	186
	% within Have you ever had more than one infection at the same time?	31.7%	12.4%	55.9%	100.0%

Statistics

Have you ever had, or would you consider having, sex with someone who you knew to be HIV positive?

N	Valid	501
	Missing	56
Mode		2.00

Have you ever had, or would you consider having, sex with someone who you knew to be HIV positive?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	189	33.9	37.7	37.7
Valid No	209	37.5	41.7	79.4
Valid Don't know/unsure	103	18.5	20.6	100.0
Valid Total	501	89.9	100.0	
Missing System	56	10.1		
Total	557	100.0		

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Would you consider having sex with someone who is poz? * Do you know anyone who is HIV-positive, or who has died from an AIDS-related illness?	499	89.6%	58	10.4%	557	100.0%

Would you consider having sex with someone who is poz? * Do you know anyone who is HIV-positive, or who has died from an AIDS-related illness? Crosstabulation

		Do you know anyone who is HIV-positive, or who has died from an AIDS-related illness?		Total
		Yes	No	
Would you consider having sex with someone who is poz?	Count	43	145	188
	% within Would you consider having sex with someone who is poz?	22.9%	77.1%	100.0%

Total	No/Don't know	Count	177	134	311
		% within Would you consider having sex with someone who is poz?	56.9%	43.1%	100.0%
		Count	220	279	499
		% within Would you consider having sex with someone who is poz?	44.1%	55.9%	100.0%

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Are you HIV positive or negative * Do you think it should be compulsory for people to explicitly reveal their HIV status on their profile?	441	79.2%	116	20.8%	557	100.0%

Are you HIV positive or negative * Do you think it should be compulsory for people to explicitly reveal their HIV status on their profile? Crosstabulation

			Do you think it should be compulsory for people to explicitly reveal their HIV status on their profile?			Total
			Yes	No	Don't know/unsure	
Are you HIV positive or negative	HIV Positive	Count	5	44	4	53
		% within Are you HIV positive or negative	9.4%	83.0%	7.5%	100.0%
HIV Negative	HIV Negative	Count	110	230	48	388
		% within Are you HIV positive or negative	28.4%	59.3%	12.4%	100.0%
Total		Count	115	274	52	441
		% within Are you HIV positive or negative	26.1%	62.1%	11.8%	100.0%

Statistics

Do you think it should be compulsory
for people to explicitly reveal their HIV
status on their profile?

N	Valid	547
	Missing	10
Mode		2.00

Do you think it should be compulsory for people to explicitly reveal their HIV status on their profile?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	161	28.9	29.4	29.4
	No	323	58.0	59.0	88.5
	Don't know/unsure	63	11.3	11.5	100.0
	Total	547	98.2	100.0	
Missing	System	10	1.8		
Total		557	100.0		

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Are you HIV positive or negative * Do you think it should be compulsory for people to explicitly reveal their HIV status on their profile?	441	79.2%	116	20.8%	557	100.0%

Are you HIV positive or negative * Do you think it should be compulsory for people to explicitly reveal their HIV status on their profile? Crosstabulation

	Do you think it should be compulsory for people to explicitly reveal their HIV status on their profile?			Total
	Yes	No	Don't know/unsure	

Are you HIV positive or negative	HIV Positive	Count	5	44	4	53
		% within Are you HIV positive or negative	9.4%	83.0%	7.5%	100.0%
	HIV Negative	Count	110	230	48	388
		% within Are you HIV positive or negative	28.4%	59.3%	12.4%	100.0%
Total	Count		115	274	52	441
	% within Are you HIV positive or negative		26.1%	62.1%	11.8%	100.0%

Statistics

Have you ever made suggestions about, or alluded to, your HIV status without actually having a direct discussion?

N	Valid	551
	Missing	6

Have you ever made suggestions about, or alluded to, your HIV status without actually having a direct discussion?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	147	26.4	26.7	26.7
	No	398	71.5	72.2	98.9
	Rather not say	6	1.1	1.1	100.0
	Total	551	98.9	100.0	
Missing	System	6	1.1		
Total		557	100.0		

Case Processing Summary

						Cases					
						Valid		Missing		Total	
						N	Percent	N	Percent	N	Percent

Have you ever made suggestions about, or alluded to, your HIV status without actually having a direct discussion? *	544	97.7%	13	2.3%	557	100.0%
What age category do you belong to?						

Have you ever made suggestions about, or alluded to, your HIV status without actually having a direct discussion? * What age category do you belong to? Crosstabulation

		What age category do you belong to?					Total
		18-24	25-30	31-40	41-50	51+	
Have you ever made suggestions about, or alluded to, your HIV status without actually having a direct discussion?	Count	26	30	33	44	14	147
	% within Have you ever made suggestions about, or alluded to, your HIV status without actually having a direct discussion?	17.7%	20.4%	22.4%	29.9%	9.5%	100.0%
	Yes						
	Count	110	84	98	71	34	397
	% within Have you ever made suggestions about, or alluded to, your HIV status without actually having a direct discussion?	27.7%	21.2%	24.7%	17.9%	8.6%	100.0%
	No						
Total	Count	136	114	131	115	48	544
	% within Have you ever made suggestions about, or alluded to, your HIV status without actually having a direct discussion?	25.0%	21.0%	24.1%	21.1%	8.8%	100.0%

Case Processing Summary

Cases					
Valid		Missing		Total	
N	Percent	N	Percent	N	Percent

Have you ever made suggestions about, or alluded to, your HIV status without actually having a direct discussion? * Have you ever received a HIV test result?	465	83.5%	92	16.5%	557	100.0%
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Have you ever made suggestions about, or alluded to, your HIV status without actually having a direct discussion? * Have you ever received a HIV test result? Crosstabulation

		Have you ever received a HIV test result?			Total
		No, I have never received a HIV test result	Yes, I have tested positive	Yes, my last test was negative	
Have you ever made suggestions about, or alluded to, your HIV status without actually having a direct discussion?	Yes	Count 5	35	99	139
		% within Have you ever received a HIV test result?	20.8%	63.6%	25.6%
	No	Count 19	19	284	322
		% within Have you ever received a HIV test result?	79.2%	34.5%	73.6%
	Rather not say	Count 0	1	3	4
		% within Have you ever received a HIV test result?	0.0%	1.8%	0.8%
Total		Count 24	55	386	465
		% within Have you ever received a HIV test result?	100.0%	100.0%	100.0%

Case Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
\$alludecombined ^a	142	25.5%	415	74.5%	557	100.0%

a. Dichotomy group tabulated at value 1.

\$alludecombined Frequencies

	Responses		Percent of Cases
	N	Percent	
I state on my profile that I have safer sex all the time	78	30.1%	54.9%
I drop various hints for him to pick up on	47	18.1%	33.1%
I engage in sex which I associate with a particular HIV status	21	8.1%	14.8%
I leave condoms around when he comes for sex	44	17.0%	31.0%
I leave my HIV drugs in a visible place so he can see them	1	0.4%	0.7%
Allusions ^a I mentioned that some of my friends are the same HIV status as me	9	3.5%	6.3%
I told him that there is no need for condoms with me	19	7.3%	13.4%
I tell him that I work for a HIV organisation	2	0.8%	1.4%
I state on my profile that I have a positive outlook on life	4	1.5%	2.8%
None of the above	16	6.2%	11.3%
Other	18	6.9%	12.7%
Total	259	100.0%	182.4%

a. Dichotomy group tabulated at value 1.

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
What mechanisms have you used to allude to your HIV status (tick all that apply)? * Are you HIV positive or negative	329	59.1%	228	40.9%	557	100.0%

What mechanisms have you used to allude to your HIV status (tick all that apply)? * Are you HIV positive or negative Crosstabulation

			Are you HIV positive or negative		Total
			HIV Positive	HIV Negative	
What mechanisms have you used to allude to your HIV status (tick all that apply)?	I told him that there is no need for condoms with me	Count	7	11	18
		% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	38.9%	61.1%	100.0%
		Count	20	291	311
		% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	6.4%	93.6%	100.0%
Total	9.00	Count	27	302	329
		% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	8.2%	91.8%	100.0%

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
What mechanisms have you used to allude to your HIV status (tick all that apply)? * Are you HIV positive or negative	353	63.4%	204	36.6%	557	100.0%

What mechanisms have you used to allude to your HIV status (tick all that apply)? * Are you HIV positive or negative Crosstabulation

		Are you HIV positive or negative		Total
		HIV Positive	HIV Negative	
Count		14	28	42

What mechanisms have you used to allude to your HIV status (tick all that apply)?	I drop various hints for him to pick up on	% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	33.3%	66.7%	100.0%
		Count	20	291	311
		% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	6.4%	93.6%	100.0%
		Count	34	319	353
Total	9.00	% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	9.6%	90.4%	100.0%

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
What mechanisms have you used to allude to your HIV status (tick all that apply)? * Are you HIV positive or negative	383	68.8%	174	31.2%	557	100.0%

What mechanisms have you used to allude to your HIV status (tick all that apply)? * Are you HIV positive or negative Crosstabulation

			Are you HIV positive or negative		Total
			HIV Positive	HIV Negative	
What mechanisms have you used to allude to your HIV status (tick all that apply)?	I state on my profile that I have safer sex all the time	Count	8	64	72
		% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	11.1%	88.9%	100.0%
	9.00	Count	20	291	311

Total	% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	6.4%	93.6%	100.0%
	Count	28	355	383
	% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	7.3%	92.7%	100.0%

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
What mechanisms have you used to allude to your HIV status (tick all that apply)? * Are you HIV positive or negative	353	63.4%	204	36.6%	557	100.0%

What mechanisms have you used to allude to your HIV status (tick all that apply)? * Are you HIV positive or negative Crosstabulation

			Are you HIV positive or negative		Total
			HIV Positive	HIV Negative	
What mechanisms have you used to allude to your HIV status (tick all that apply)?	Count		14	28	42
	I drop various hints for him to pick up on	% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	33.3%	66.7%	100.0%
	Count		20	291	311
	9.00	% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	6.4%	93.6%	100.0%
Total	Count		34	319	353

% within What mechanisms have you used to allude to your HIV status (tick all that apply)?	9.6%	90.4%	100.0%
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Statistics

Have you ever deliberately sought a partner who was HIV-positive and had an undetectable viral load?

N	Valid	188
	Missing	369
Mode		2.00

Have you ever deliberately sought a partner who was HIV-positive and had an undetectable viral load?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	13	2.3	6.9	6.9
Valid No	175	31.4	93.1	100.0
Total	188	33.8	100.0	
Missing System	369	66.2		
Total	557	100.0		

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever deliberately sought a partner who was HIV-positive and had an undetectable viral load? *	143	25.7%	414	74.3%	557	100.0%
Have you ever intentionally sought bb sex for someone you have had sex with?						

Have you ever deliberately sought a partner who was HIV-positive and had an undetectable viral load? * Have you ever intentionally sought bb sex for someone you have had sex with?

Crosstabulation

		Have you ever intentionally sought bb sex for someone you have had sex with?		Total
		Yes	No	
Have you ever deliberately sought a partner who was HIV-positive and had an undetectable viral load?	Count	11	1	12
	% within Have you ever	19.0%	1.2%	8.4%
	Yes intentionally sought bb sex for someone you have had sex with?			
	Count	47	84	131
	% within Have you ever	81.0%	98.8%	91.6%
	No intentionally sought bb sex for someone you have had sex with?			
Total	Count	58	85	143
	% within Have you ever intentionally sought bb sex for someone you have had sex with?	100.0%	100.0%	100.0%

Statistics

When having anal sex without a condom as a neg man, do you ever withdraw before coming?

N	Valid	346
	Missing	211
Median		3.0000

When having anal sex without a condom as a neg man, do you ever withdraw before coming?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	59	10.6	17.1
	Rarely	66	11.8	36.1
	Sometimes	131	23.5	74.0

Often	27	4.8	7.8	81.8
Very often	22	3.9	6.4	88.2
Always	41	7.4	11.8	100.0
Total	346	62.1	100.0	
Missing System	211	37.9		
Total	557	100.0		

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
When having anal sex without a condom as a neg man, do you ever withdraw before coming? * Have you ever intentionally sought bb sex for someone you have had sex with?	319	57.3%	238	42.7%	557	100.0%

When having anal sex without a condom as a neg man, do you ever withdraw before coming? *

Have you ever intentionally sought bb sex for someone you have had sex with? Crosstabulation

			Have you ever intentionally sought bb sex for someone you have had sex with?		Total
			Yes	No	
When having anal sex without a condom as a neg man, do you ever withdraw before coming?	Never	Count	28	24	52
		% within Have you ever intentionally sought bb sex for someone you have had sex with?	25.9%	11.4%	16.3%
	Rarely	Count	26	35	61
		% within Have you ever intentionally sought bb sex for someone you have had sex with?	24.1%	16.6%	19.1%
	Sometimes	Count	35	85	120

Total		% within Have you ever intentionally sought bb sex for someone you have had sex with?		32.4%	40.3%	37.6%
				8	17	25
				7.4%	8.1%	7.8%
				5	15	20
				4.6%	7.1%	6.3%
				6	35	41
				5.6%	16.6%	12.9%
				108	211	319
				100.0%	100.0%	100.0%

Statistics

Are you, as a neg man, more likely to take an active/top role when barebacking with others?

N	Valid	289
	Missing	268
Mode		2.00

Are you, as a neg man, more likely to take an active/top role when barebacking with others?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Yes	97	17.4	33.6	33.6
Valid No	192	34.5	66.4	100.0

Total	289	51.9	100.0
Missing System	268	48.1	
Total	557	100.0	

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Are you more likely to take a top/active role when barebacking? * How would you describe your sexual role?	339	60.9%	218	39.1%	557	100.0%

Are you more likely to take a top/active role when barebacking? * How would you describe your sexual role? Crosstabulation

		How would you describe your sexual role?					Total
		Top only	Mainly top, but occasionally bottom	Versatile	Mainly bottom, but occasionally top	Bottom only	
Are you more likely to take a top/active role when barebacking?	Count	13	33	44	19	2	111
	% within	76.5%	70.2%	33.6%	19.2%	4.4%	32.7%
	How would you describe your sexual role?						
	Count	4	14	87	80	43	228
	% within	23.5%	29.8%	66.4%	80.8%	95.6%	67.3%
	How would you describe your sexual role?						
Total		17	47	131	99	45	339

% within	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
How would you describe your sexual role?						

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever intentionally sought bb sex for someone you have had sex with? * Are you, as a neg man, more likely to take an active/top role when barebacking with others?	267	47.9%	290	52.1%	557	100.0%

Have you ever intentionally sought bb sex for someone you have had sex with? * Are you, as a neg man, more likely to take an active/top role when barebacking with others? Crosstabulation

		Are you, as a neg man, more likely to take an active/top role when barebacking with others?		Total
		Yes	No	
Have you ever intentionally sought bb sex for someone you have had sex with?	Count	35	56	91
	% within Have you ever	38.5%	61.5%	100.0%
	Yes intentionally sought bb sex for someone you have had sex with?			
	Count	54	122	176
Have you ever intentionally sought bb sex for someone you have had sex with?	% within Have you ever	30.7%	69.3%	100.0%
	No intentionally sought bb sex for someone you have had sex with?			

Total	Count	89	178	267
	% within Have you ever intentionally sought bb sex for someone you have had sex with?	33.3%	66.7%	100.0%

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Are you more likely to take a top/active role when barebacking? * Are you HIV positive or negative	298	53.5%	259	46.5%	557	100.0%

Are you more likely to take a top/active role when barebacking? * Are you HIV positive or negative

Crosstabulation

			Are you HIV positive or negative		Total
			HIV Positive	HIV Negative	
Are you more likely to take a top/active role when barebacking?	Yes, I am more likely to take a top role	Count	14	85	99
		% within Are you HIV positive or negative	29.2%	34.0%	33.2%
	No, I do not change my role	Count	34	165	199
		% within Are you HIV positive or negative	70.8%	66.0%	66.8%
Total	Count		48	250	298
	% within Are you HIV positive or negative		100.0%	100.0%	100.0%

Are you more likely to take a top/active role when barebacking? * How would you describe your sexual role? Crosstabulation

			How would you describe your sexual role?					Total
			Top only	Mainly top, but occasionally bottom	Versatile	Mainly bottom, but occasionally top	Bottom only	
Are you more likely to take a top/active role when barebacking?	Count		13	33	44	19	2	111
	% within		76.5%	70.2%	33.6%	19.2%	4.4%	32.7%
	Yes, I am more likely to take a top role	How would you describe your sexual role?						
	Count		4	14	87	80	43	228
	% within		23.5%	29.8%	66.4%	80.8%	95.6%	67.3%
	No, I do not change my role	How would you describe your sexual role?						
Total	Count		17	47	131	99	45	339
	% within		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	How would you describe your sexual role?							

Case Processing Summary

						Cases					
						Valid		Missing		Total	
						N	Percent	N	Percent	N	Percent

Have you ever made an agreement with a sex partner of the same HIV status to bb with one another? * Are you HIV positive or negative	345	61.9%	212	38.1%	557	100.0%
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Statistics

Have you ever made an agreement with a sex partner of the same seronegative status to bb with one another?

N	Valid	397
	Missing	160
Mode		2.00

Have you ever made an agreement with a sex partner of the same seronegative status to bb with one another?

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	163	29.3	41.1
	No	184	33.0	87.4
	I'm HIV+	50	9.0	100.0
	Total	397	71.3	100.0
Missing	System	160	28.7	
Total		557	100.0	

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever intentionally sought bb sex from someone who is also neg? * Have you ever made an agreement with a sex partner of the same seronegative status to bb with one another?	319	57.3%	238	42.7%	557	100.0%

Have you ever intentionally sought bb sex from someone who is also neg? * Have you ever made an agreement with a sex partner of the same seronegative status to bb with one another?

Crosstabulation

		Have you ever made an agreement with a sex partner of the same seronegative status to bb with one another?		Total
		Yes	No	
Have you ever intentionally sought bb sex from someone who is also neg?	Count	76	30	106
	% within Have you ever	71.7%	28.3%	100.0%
	Yes intentionally sought bb sex from someone who is also neg?			
	Count	75	138	213
	% within Have you ever	35.2%	64.8%	100.0%
	No intentionally sought bb sex from someone who is also neg?			
Total	Count	151	168	319
	% within Have you ever intentionally sought bb sex from someone who is also neg?	47.3%	52.7%	100.0%

Have you ever made an agreement with a sex partner of the same HIV status to bb with one another? * Are you HIV positive or negative Crosstabulation

		Are you HIV positive or negative		Total
		HIV Positive	HIV Negative	
Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	Count	35	139	174
	% within Are you	70.0%	47.1%	50.4%
	Yes HIV positive or negative			
	Count	15	156	171
	% within Are you	30.0%	52.9%	49.6%
	No HIV positive or negative			

Total	Count	50	295	345
	% within Are you	100.0%	100.0%	100.0%
	HIV positive or negative			

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever made an agreement with a sex partner of the same HIV status to bb with one another? * Have you ever tested for HIV or STIs	400	71.8%	157	28.2%	557	100.0%

Have you ever made an agreement with a sex partner of the same HIV status to bb with one another? * Have you ever tested for HIV or STIs Crosstabulation

		Have you ever tested for HIV or STIs		Total
		Yes	No	
Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	Count	178	21	199
	% within Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	89.4%	10.6%	100.0%
Total	Count	180	21	201
	% within Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	89.6%	10.4%	100.0%
Total	Count	358	42	400
	% within Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	89.5%	10.5%	100.0%

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Have you ever made an agreement with a sex partner of the same HIV status to bb with one another? * I have a HIV and/or STI test approx	357	64.1%	200	35.9%	557	100.0%

Have you ever made an agreement with a sex partner of the same HIV status to bb with one another? * I have a HIV and/or STI test approx Crosstabulation

		I have a HIV and/or STI test approx				Total
		Once every 3 months	Once every six months	Once a year	Less frequently	
Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	Count	35	58	47	38	178
	% within Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	19.7%	32.6%	26.4%	21.3%	100.0%
	Yes					
	Count	18	39	53	69	179
Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	% within Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	10.1%	21.8%	29.6%	38.5%	100.0%
	No					
	Count	53	97	100	107	357
	% within Have you ever made an agreement with a sex partner of the same HIV status to bb with one another?	14.8%	27.2%	28.0%	30.0%	100.0%
Total						